

<b>Case Number:</b>	CM14-0194002		
<b>Date Assigned:</b>	12/01/2014	<b>Date of Injury:</b>	02/12/2003
<b>Decision Date:</b>	01/15/2015	<b>UR Denial Date:</b>	10/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/19/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 66 year old patient with date of injury of 02/12/2003. Medical records indicate the patient is undergoing treatment for lumbar disc displacement, lumbosacral spondylosis, lumbar spine discopathy and multilevel discopathy with lumbar radiculopathy. Subjective complaints include low back pain and left leg numbness, rated 7-8/10 described as aching and stiffness and neck pain rated 8/10. Objective findings include tenderness of paraspinous musculature of lumbar spine with midline tenderness and spasm noted. Patient's lumbar range of motion - flexion 15 degrees, extension 10, right rotation 10, left rotation 5, right tilt 10, left tilt 5; sensation decreased on the left L3-4, L4-5 and L5-S1. Patient's muscle strength 4/5 in left quadriceps, plantar flexor and toe extensor; reflexed on left knee and ankle; sciatic nerve compression and straight leg raise positive on the left. Treatment has consisted of Naproxen, Hydrocodone and Toradol. The utilization review determination was rendered on 10/23/2014 recommending non-certification of Hydrocodone/APAP 10/325mg #60 and Gabapentin 10%, Cyclobenzaprine 4%, Ketoprofen 10%, Capsaicin 0.0375%, Menthol 5%, Camphor 2% cream 180gm.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Hydrocodone/APAP 10/325mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Norco, Opioids, and Criteria for Use: When to Discontinue Opioids;.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic)

**Decision rationale:** ODG does not recommend the use of opioids for low back pain "except for short use for severe cases, not to exceed 2 weeks." The patient has exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. Additionally, medical documents indicate that the patient has been on Norco in excess of the recommended 2-week limit. As such, the question for Hydrocodone/APAP 10/325mg #60 is not medically necessary.

**Gabapentin 10%, Cyclobenzaprine 4%, Ketoprofen 10%, Capsaicin 0.0375%, Menthol 5%, Camphor 2% cream 180gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medications, Topical NSAIDs: Capsaicin, Topical: Menthol..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Capsaicin Page(s): 111-113, 28. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound Creams.

**Decision rationale:** MTUS and ODG recommend usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." MTUS recommends topical Capsaicin "only as an option in patients who have not responded or are intolerant to other treatments." There is no indication that the patient has failed oral medication or is intolerant to other treatments. Additionally, ODG states "Topical OTC pain relievers that contain Menthol, Methyl Salicylate, or Capsaicin, may in rare instances can cause serious burns, a new alert from the FDA warns." Guidelines recommend against compounded products that contain at least one drug or drug class that is not recommended, neither topical Cyclobenzaprine nor Gabapentin are recommended. As such, the request for Gabapentin 10%, Cyclobenzaprine 4%, Ketoprofen 10%, Capsaicin 0.0375%, and Menthol 5%, Camphor 2% cream 180gm is not medically necessary.

