

<b>Case Number:</b>	CM15-0001995		
<b>Date Assigned:</b>	01/13/2015	<b>Date of Injury:</b>	04/20/2001
<b>Decision Date:</b>	03/16/2015	<b>UR Denial Date:</b>	12/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/05/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### CLINICAL CASE SUMMARY

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

The injured worker is a 47-year-old male with a date of injury of 04/20/2001. Diagnoses include status post lumbar spine surgery, cervicothoracic spine sprain and strain, cervical discopathy per the MRI, bilateral shoulder pain, status post spinal decompression and fusion and status post pain implant stimulator. Past treatments include therapy and medications surgery. On 11/05/2014, the injured worker presented with complaints of pain in the spine and the leg and in his neck and shoulders, which he rated as an 8/10. He complains of pain in his back, which he rated as an 8/10 and stated he has pins and needles sensation in his hands with occasional aching and burning sensation in his legs. His objective findings included normal examination and range of motion of the hands and wrists. Examination of the lumbar spine revealed spinal cord stimulator in good position, tenderness in the paraspinous musculature and midline tenderness is noted in the lumbar region. Range of motion for the lumbar area is flexion 20 degrees, extension 15 degrees, rotation right 15 degrees, rotation left 10 degrees and tilt right and left 15 degrees, sensation testing with pinwheel is slightly abnormal. Motor strength test is normal. Deep tendon reflexes are normal. The treatment plan is to continue his current medication and the rationale is the injured worker has a chronic condition which he needs his medications long term. The Request for Authorization was dated 12/03/2014 was present.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Topical compound gabapentin/cyclobenzaprine/ketoprofen/capsaicin/menthol/camphor 10/4/10/0.0375/5/2% cream 240g:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** The request for gabapentin/cyclobenzaprine/ketoprofen/capsaicin/menthol/camphor 10/4/10/0.0375/5/2% cream 240g is not medically necessary. The California MTUS Guidelines state many agents are compounded as monotherapy or in combination for pain control including NSAIDs, opiates, capsaicin, local anesthetics, antidepressants and is largely experimental in use with few randomized controlled trials to determine efficacy. Gabapentin, there is no peer reviewed literature to support its use. Cyclobenzaprine is a muscle relaxant and there is no evidence of any support for uses of topical product. Ketoprofen is not approved due to its high incidents of photocontact dermatitis. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments; and menthol, there are no evidence based recommendations regarding the topical application of menthol. Therefore, the request for the topical compound is not medically necessary.

**Topical compound flurbiprofen/baclofen/gabapentin/lidocaine 12/2/6/4% cream 240g:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** The California MTUS Guidelines state topical analgesics are primarily recommended for neuropathic pain after trials of antidepressants and anticonvulsants have failed. The compound product that contains at least 1 drug that is not recommended will not be recommended. NSAIDs, such as Flurbiprofen, are recommended for osteoarthritis and tendinitis for short term use 4 to 12 weeks. Baclofen is not recommended due to lack of peer reviewed literature to support it. Gabapentin is not recommended. The guidelines state that the Lidoderm patch is the only topical form of lidocaine that is FDA approved. Therefore, the request for topical compound is not medically necessary.

**1 Lumbar spine corset:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back/ Lumbar supports

**Decision rationale:** The request for 1 lumbar spine corset is not medically necessary. The California MTUS/ACOEM Guidelines do not address this. The Official Disability Guidelines recommend the use of lumbar supports for compression fractures, in spondylosis and documented instability. There is no clinical documentation to indicate the patient suffers from compression fractures, spondylosis or instability in the lumbar spine. Therefore, the request for 1 lumbar spine corset is not medically necessary.

**Unknown prescription of soma:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29.

**Decision rationale:** The decision for unknown prescription of Soma. According to the California MTUS Guidelines, Soma is not recommended for long term use. It is a commonly prescribed central acting skeletal muscle relaxant. Its primary active metabolite is meprobamate. There is lack of objective documentation of the injured worker's beneficial response to the use of Soma. The request did not indicate the dosage, the frequency or amount of the medication. Therefore, the medication is not medically necessary.

**Unknown prescription of tramadol:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 94.

**Decision rationale:** The request for tramadol is not medically necessary. The California MTUS Guidelines recommend ongoing review of patients utilizing chronic opioid medications with documentation of pain relief, functional status, appropriate medication use and side effects. A complete pain assessment should be documented, which includes current pain, least reported pain over the period since the last assessment, average pain, intensity of pain after taking the opioid, how long the pain relief takes and how long relief lasts. The guidelines also recommend providers assess for side effects and occurrence of any potentially aberrant drug related behaviors. The most recent clinical note failed to document evidence of quantifiable pain relief and objective functional improvement with the use of tramadol. The request also did not indicate the frequency, the dosage, the amount of the requested tramadol. Therefore, the request is not medically necessary.

**Unknown prescription of gabapentin:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Gabapentin Page(s): 18.

**Decision rationale:** The request for an unknown prescription of gabapentin is not medically necessary. The for diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first line treatment for neuropathic pain. There lack of documentation of the efficacy of the medication. The provider's rationale was not provided. The provider's request does not indicate the frequency, dosage and amount of this medication. As such, the request is not medically necessary.