

Case Number:	CM15-0135328		
Date Assigned:	07/23/2015	Date of Injury:	09/24/2012
Decision Date:	09/30/2015	UR Denial Date:	06/09/2015
Priority:	Standard	Application Received:	07/13/2015

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: New York

Certification(s)/Specialty: Internal Medicine

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 60 year old female, who sustained an industrial injury on 9/24/12. The injured worker has complaints of bilateral wrist pain. The documentation noted that right wrist range of motion flexion is 40 degrees and extension is 40 degrees. The diagnoses have included bilateral wrist sprain and strain. Treatment to date has included right wrist brace; Terocin patch; Lyrica; compound topical cream and home exercise program. The request was for Flurbi (NAP) cream 180 grams Flurbi 20%, lidocaine 5%, amitriptyline 4%; Gabacyclotram 180gm: gabapentin 10%, Cyclo 6%, tramadol 10%; Genicin cap #90; Terocin 240ml: capsaicin 0.025%, methyl Salicylate 25%, menthol 10%, lido 2.5%; Trazadone 50mg (quantity unspecified); Somnicin #30; Theramine #90 and Lyrica 50mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbi (NAP) cream 180 grams Flurbi 20%, Lidocaine 5%, Amitriptyline 4%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. The requested topical analgesic compound for this patient contains: Flurbiprofen 15%, Cyclobenzaprine 2%, Amitriptyline 4%, and Lidocaine 5%. MTUS guidelines state that Flurbiprofen, lidocaine, and Amitriptyline are not recommended for topical applications. Medical necessity for the requested topical analgesic compounded medication, for muscular pain, has not been established. The requested topical compound is not medically necessary.

Gabacyclotram 180gm: Gabapentin 10%, Cyclo 6%, Tramadol 10%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the topical analgesic requested is topical Gabapentin cream. Gabapentin and Tramadol are not recommended as a topical agent per CA MTUS Guidelines. There is no peer-reviewed literature to support its use. It is evident from the records that the patient is able to use oral medications and there is no rationale provided for the use of topical cream. Medical necessity for the requested topical analgesic cream has not been established. The request for the topical analgesic is not medically necessary.

Genicin cap #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 50.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Genicin (Glucosamine).

Decision rationale: According to the ODG, Genicin (glucosamine) is not recommended for the treatment of low back pain. Glucosamine is not significantly different from placebo for reducing pain-related disability or improving health-related quality of life in patients with chronic low back pain (LBP) and degenerative lumbar osteoarthritis, and it should not be recommended for patients with lower back pain. Glucosamine is a precursor molecule involved in building tendons, ligaments, and cartilage. It is hypothesized to restore cartilage and to have anti-inflammatory properties, and, despite conflicting data on its efficacy, has become widely used as a treatment for osteoarthritis. It has also become more widely used for LBP, including degenerative lumbar osteoarthritis. In this case, the patient has bilateral wrist pain and there is no indication for the use of Genicin in the treatment of chronic wrist pain. Medical necessity for the requested medication has not been established. This medication is not medically necessary.

Terocin 240ml: Capsaicin 0.025%, Methyl Salicylate 25%, Menthol 10%, Lido 2.5%:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: According to the California MTUS Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, local anesthetics or antidepressants. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case, there is no documentation provided necessitating Terocin. This medication contains methyl salicylate, capsaicin, menthol, and lidocaine. MTUS states that capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. There is no documentation of intolerance to other previous oral medications. Medical necessity for the requested topical medication has not been established. The requested treatment is not medically necessary.

Trazadone 50mg (quantity unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants (for pain).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic pain, insomnia.

Decision rationale: Trazodone (Desyrel) is recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. It is unrelated to tricyclic or tetracyclic antidepressants and has some action as an anxiolytic. In this case, there is no documentation of a history of depression, anxiety or insomnia. Medical necessity of the requested medication has not been established. The requested medication is not medically necessary.

Somnicin #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic pain, insomnia.

Decision rationale: According to the ODG, melatonin is recommended for insomnia treatment. Melatonin also has an analgesic effect in patients with chronic pain. Somnicin contains melatonin, 5-HTP, L-tryptophan, Vitamin B6 and magnesium. There is no documentation indicating that this patient has a sleep disturbance. In addition, the provider requested Trazodone which is used in the treatment of insomnia. Medical necessity for the requested item has not been established. The requested medication is not medically necessary.

Theramine #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Theramine.

Decision rationale: According to the ODG, Theramine is an FDA regulated medical food designed to address the increased nutritional requirements associated with chronic pain syndromes and low back pain. Its mechanism of action is the production of neurotransmitters that help manage and improve the sensory response to pain and inflammation. This medication contains 5-hydroxytryptophan 95%, choline bitartrate, L-arginine, histidine, L-glutamine, L-serine, gamma-aminobutyric acid (GABA), whey protein concentrates, grape seed extract 85%, cinnamon, and cocoa. There is no medical literature that supports the use of this medication for the treatment of chronic pain. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Lyrica 50mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lyrica Page(s): 58.

Decision rationale: According to California MTUS Guidelines, anti-epilepsy medications are a first-line treatment for neuropathic pain. Lyrica is FDA approved for diabetic neuropathy and post-herpetic neuralgia and has been used effectively for the treatment of other neuropathic pain. A 'good' response to therapy with this medication is described as a 50% reduction in complaints of neuropathic pain. In this case, this patient has bilateral wrist pain with no documentation of neuropathic pain. There is no indication for the use of Lyrica. Medical necessity for the requested medication has not been established. The requested item is not medically necessary.