

<b>Case Number:</b>	CM15-0180428		
<b>Date Assigned:</b>	09/22/2015	<b>Date of Injury:</b>	08/12/2003
<b>Decision Date:</b>	11/13/2015	<b>UR Denial Date:</b>	08/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/14/2015

### 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, Pain Management

### 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 58 year old male, who sustained an industrial injury on 8-12-2003. The medical records indicate that the injured worker is undergoing treatment for status post cervical spine surgery (1-29-2015), unspecified musculoskeletal disorder and symptoms referable to the neck, thoracic or lumbosacral neuritis or radiculitis, traumatic rotator cuff tear, cervical neuritis-radiculopathy, pain in thoracic spine, anxiety, and depressive disorder. According to the progress report dated 5-19-2015, the injured worker presented for follow up. He reports new intermittent numbness in the left hand. Per notes, range of motion and strength are unchanged since last visit. On a subjective pain scale, he rates his pain 7 out of 10. The physical examination reveals tenderness to palpation of the upper back, mid back, neck, and bilateral upper extremities. There is numbness in the bilateral upper extremities over the left C7-C8 dermatomes. The current medications are Norco, Terocin patch, Somnicin, and topical compound cream. There is documentation of ongoing treatment with Norco since at least 1-29-2015 and Terocin patch, Somnicin, and topical compound cream since at least 2-27-2014. Previous diagnostic studies include x-rays and MRI studies. Treatments to date include medication management, chiropractic, and surgical intervention. Physical therapy remains on hold. Work status is described as not working. The original utilization review (8-20-2015) partially approved a request for Norco #30 (original request was for #40); the request for Terocin patch, Somnicin, and topical compound cream (Flurbiprofen 15% - Gabapentin 10% - Cyclobenzaprine 4%) was non-certified.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 5/325 #40:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids for osteoarthritis, Opioids, cancer pain vs. nonmalignant pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, indicators for addiction, Opioids, long-term assessment.

**Decision rationale:** Regarding the request for Norco (hydrocodone/acetaminophen), California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Norco (hydrocodone/acetaminophen) is not medically necessary.

**Flurbiprofen 15%/ Gabapentin 10%/ Cyclobenzaprine 4% cream, 180gm with 2 refills:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** Regarding the request for Flurbiprofen 15%/ Gabapentin 10%/ Cyclobenzaprine 4% cream, 180gm with 2 refills, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Regarding topical gabapentin, Chronic Pain Medical Treatment Guidelines state that topical anti-epileptic medications are not recommended. They go on to state that there is no peer-reviewed literature to support their use. Muscle relaxants drugs are not supported by the CA MTUS for topical use. As such, the currently requested Flurbiprofen 15%/ Gabapentin 10%/ Cyclobenzaprine 4% cream, 180gm with 2 refills is not medically necessary.

**Terocin Patch (4% lidocaine and 4% menthol) #30 with 2 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** Regarding the request for Terocin, Terocin is a combination of methyl salicylate, menthol, lidocaine and capsaicin. Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug or drug class that is not recommended, is not recommended. Regarding the use of topical non-steroidal anti-inflammatory, guidelines state that the efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the 1st 2 weeks of treatment osteoarthritis, but either not afterwards, or with the diminishing effect over another two-week period. Regarding use of capsaicin, guidelines state that it is recommended only as an option for patients who did not respond to or are intolerant to other treatments. Regarding the use of topical lidocaine, guidelines state that it is recommended for localized peripheral pain after there is evidence of a trial of first-line therapy. Within the documentation available for review, there is no indication that the patient is unable to tolerate oral NSAIDs. Oral NSAIDs have significantly more guideline support compared with topical NSAIDs. Additionally, there is no indication that the topical NSAID is going to be used for short duration. Additionally, there is no documentation of localized peripheral pain with evidence of failure of first-line therapy as recommended by guidelines prior to the initiation of topical lidocaine. Finally, there is no indication that the patient has been intolerant to or did not respond to other treatments prior to the initiation of capsaicin therapy. In the absence of clarity regarding those issues, the currently requested Terocin is not medically necessary.

**Somnicin 2mg/50mg/100mg-10mg/50mg #30 with 2 refills: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic): Somnicin (2015).

**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 Chapter, Medical Food.

**Decision rationale:** Regarding the request for SOMNICIN, a search of the Internet indicates that SOMNICIN is a medical food. California MTUS and ACOEM guidelines do not contain criteria for the use of medical foods. ODG states that medical foods are recommended for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements. Within the documentation available for review, the requesting physician has not indicated that this patient has any specific nutritional deficits. Additionally, there are no diagnoses, conditions, or medical disorders for which distinctive nutritional requirements are present. In the absence of such documentation, the currently requested SOMNICIN is not medically necessary.