MAXIMUS Federal Services

Case Number:	CM15-0203410		
Date Assigned:	10/20/2015	Date of Injury:	09/10/2014
Decision Date:	12/29/2015	UR Denial Date:	10/07/2015
Priority:	Standard	Application Received:	10/15/2015

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: Tennessee, Florida, Ohio
Certification(s)/Specialty: Surgery, Surgical Critical Care

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 54 year old male, who sustained an industrial injury on 9-10-2014. A review of the medical records indicates that the injured worker is undergoing treatment for cervical spine sprain-strain with decreased disc height at C6-C7 with spondylosis, left shoulder sprain-strain, acromioclavicular osteophytes, and narrowing of the acromiohumeral interval, right shoulder sprain-strain, acromioclavicular osteophytes and narrowing of the acromio-clavicular joint and acromiohumeral interval, bilateral carpal tunnel syndrome, bilateral cubital tunnel syndrome, right C7 radiculopathy, and lumbar spine sprain-strain. On 6-4-2015, the injured worker reported his cervical spine complaints unchanged with pain radiating to the shoulders, stiffness in the cervical spine with occasional spasms, increased neck pain with prolonged positioning, left shoulder complaints unchanged, right shoulder complaints worsened with increased pain, weakness in the shoulders, unchanged left wrist complaints, worsened right wrist complaints, and lumbar spine unchanged with limited motion and occasional spasms. On 7-30-2015, the injured worker reported cervical spine complaints with pain that radiated to the shoulders and occasionally down the right arm, bilateral shoulder complaints, bilateral wrist complaints, numbness of the right hand and weakness, and lumbar spine complaints with pain that radiates down the left thigh with numbness and tingling. The Primary Treating Physician's report dated 6-4-2015, noted the injured worker was not working, continuing to be using Mobic, Flexeril, and Terocin cream. The physical examination was noted to show decreased cervical spine range of motion (ROM), numbness and tingling in the right hand, decreased bilateral elbow range of motion (ROM), and decreased bilateral wrist range of motion (ROM). The

treatment plan was noted to include medications provided including Mobic, Flexeril, and Terocin cream. On 7-30-2015, the injured worker was noted to be using Mobic, Flexeril, and Terocin cream, with the treatment plan was noted to include the medications dispensed. The request for authorization dated 9-25-2015, requested retrospective Mobic 15mg, #30 (DOS: 07/30/2015), retrospective Flexeril 7.5mg, #90 (DOS: 07/30/2015), retrospective Terocin lotion 120ml (DOS: 07/30/2015), retrospective Mobic 15mg, #30 (DOS: 06/04/2015), retrospective Flexeril 7.5mg, #90 (DOS: 06/04/2015), and retrospective Terocin lotion 120ml (DOS: 06/04/2015). The Utilization Review (UR) dated 10-7-2015, approved the request for retrospective Mobic 15mg, #30 (DOS: 07/30/2015), and non-certified the requests for retrospective Flexeril 7.5mg, #90 (DOS: 07/30/2015), retrospective Terocin lotion 120ml (DOS: 07/30/2015), retrospective Mobic 15mg, #30 (DOS: 06/04/2015), retrospective Flexeril 7.5mg, #90 (DOS: 06/04/2015), and retrospective Terocin lotion 120ml (DOS: 06/04/2015).

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Terocin lotion 120ml (DOS: 06/04/2015): Upheld

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

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

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this medication for this patient. Per the California MTUS Chronic Pain guidelines, topical analgesics are recommended as an option and are largely experimental in use with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended as a whole. Terocin cream is a combination of methyl salicylate, capsaicin, menthol, and lidocaine. Topical lidocaine, in the formulation of a dermal patch, has been designated for neuropathic pain by the FDA. No other commercially-approved topical formulation of lidocaine is indicated for neuropathic pain. The clinical information submitted for review fails to provide evidence of a failure to respond to antidepressants or anticonvulsants prior to the request for an initiation of a topical analgesic. Hence the request for Terocin is not appropriate or indicated by MTUS guidelines. Therefore, based on the submitted medical documentation, the request for Terocin is not medically necessary.

Retrospective Flexeril 7.5mg, #90 (DOS: 06/04/2015): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril).

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. In accordance with the California MTUS guidelines, Cyclobenzaprine is a muscle relaxant and muscle relaxants are not recommended for the treatment of chronic pain. From the MTUS guidelines: Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic back pain. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. This patient has been diagnosed with chronic back pain of the cervical spine. Per MTUS, the use of a muscle relaxant is not indicated. Therefore, based on the submitted medical documentation, the request for Cyclobenzaprine is not-medically necessary.

Retrospective Mobic 15mg, #30 (DOS: 06/04/2015): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Anti-inflammatory medications.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. Mobic is an NSAID (non-steroidal anti-inflammatory drug). The MTUS guidelines do not provide for information on Mobic for Pain management. According to the guidelines: Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. Mobic is a COX2 inhibitor; its use over traditional NSAID therapy is not indicated since there is no justification for its prescription over another NSAID agent. Therefore, based on the submitted medical documentation, the request for Mobic is not medically necessary.

Retrospective Terocin lotion 120ml (DOS: 07/30/2015): Upheld

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

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

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this medication for this patient. Per the California MTUS Chronic Pain guidelines, topical analgesics are recommended as an option and are largely experimental in use with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug or drug class that is not recommended is not

recommended as a whole. Terocin cream is a combination of methyl salicylate, capsaicin, menthol, and lidocaine. Topical lidocaine, in the formulation of a dermal patch, has been designated for neuropathic pain by the FDA. No other commercially-approved topical formulation of lidocaine is indicated for neuropathic pain. The clinical information submitted for review fails to provide evidence of a failure to respond to antidepressants or anticonvulsants prior to the request for an initiation of a topical analgesic. Hence the request for Terocin is not appropriate or indicated by MTUS guidelines. Therefore, based on the submitted medical documentation, the request for terocin is not medically necessary.

Retrospective Flexeril 7.5mg, #90 (DOS: 07/30/2015): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril).

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. In accordance with the California MTUS guidelines, Cyclobenzaprine is a muscle relaxant and muscle relaxants are not recommended for the treatment of chronic pain. From the MTUS guidelines: Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic back pain. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. This patient has been diagnosed with chronic back pain of the cervical spine. Per MTUS, the use of a muscle relaxant is not indicated. Therefore, based on the submitted medical documentation, the request for Cyclobenzaprine is not-medically necessary.