

<b>Case Number:</b>	CM14-0119743		
<b>Date Assigned:</b>	09/24/2014	<b>Date of Injury:</b>	07/15/2010
<b>Decision Date:</b>	10/29/2014	<b>UR Denial Date:</b>	07/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/28/2014

### 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 General Preventive Medicine, and is licensed to practice in Indiana. 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 employee is a 43 year old female with date of injury of 7/15/2010. A review of the medical records indicate that the patient is undergoing treatment for cervical, thoracic, and lumbar pain with radiculopathy, right knee strain and right ankle strain. Subjective complaints include pain in her neck and low back. Objective findings include decreased range of motion of cervical and lumbar spines, positive straight leg raise, painful motion of bilateral knees, MRI findings showing a 5mm herniation of the C6-C7 spine. Treatment has included Hydrocodone, Cyclobenzaprine and Biotherm. The utilization review dated 7/1/2014 non-certified Gabapentin/ Pyridoxine, Flurbiprofen/ ranitidine, Flurbiprofen 20%/ Cyclobenzaprine 10%/ Menthyl 4%, Keratek Analgesic Gel, and Hydrocodone.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Gabapentin/ Pyridoxine 250mg / 10mg #60 + 3 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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs Page(s): 16-22. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Anti-epilepsy drugs (AEDs) for pain, Gabapentin (Neurontin)

**Decision rationale:** The MTUS considers Gabapentin as a first-line treatment for neuropathic pain and effective for the treatment of spinal cord injury, lumbar spinal stenosis, and post op pain. MTUS also recommends a trial of Gabapentin for complex regional pain syndrome. ODG states "Recommended Trial Period: One recommendation for an adequate trial with Gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. (Dworkin, 2003) The patient should be asked at each visit as to whether there has been a change in pain or function. Current consensus based treatment algorithms for diabetic neuropathy suggests that if inadequate control of pain is found, a switch to another first-line drug is recommended." Additionally, ODG states that Gabapentin "has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain". Based on the clinical documentation provided, there is no evidence of neuropathic type pain or radicular pain on exam or subjectively. As such, without any evidence of neuropathic type pain, the requested Gabapentin/ Pyridoxine 250mg / 10mg #60 + 3 Refills is not medically necessary.

**Flurbiprofen/ ranitidine100/ 100mg #60 + 3 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

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

**Decision rationale:** MTUS and ODG recommends 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 states that the only FDA- approved NSAID medication for topical use includes diclofenac, which is indicated for relief of osteoarthritis pain in joints. Flurbiprofen would not be indicated for topical use in this case. The request for Flurbiprofen/ Ranitidine100/ 100mg #60 + 3 refills is not medically necessary.

**Flurbiprofen 20%/ cyclobenzaprine 10%/ menthyl 4% cream #120 gm:** Upheld

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

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

**Decision rationale:** MTUS and ODG recommends 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 states that the only FDA- approved NSAID medication for topical use includes diclofenac, which is indicated for relief of osteoarthritis pain in joints. Flurbiprofen would not be indicated for topical use in this case. The request for Flurbiprofen 20%/ Cyclobenzaprine 10%/ Menthyl 4% Cream #120 gm is not medically necessary.

**Keratek Analgesic Gel 4oz + 3 Refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate, Topical analgesic Page(s): 105, 111-113.

**Decision rationale:** Kera-Tek Gel is the brand name version of a topical analgesic medication containing menthol and methyl salicylate. ODG recommends 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." ODG only comments on menthol in the context of cryotherapy for acute pain, but does state "Topical OTC pain relievers that contain menthol, methyl salicylate, or capsaicin, may in rare instances cause serious burns, a new alert from the FDA warns." MTUS states regarding topical Salicylate, "Recommended. Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain. (Mason-BMJ, 2004) See also Topical analgesics; & Topical analgesics, compounded." The medical documents do not support the use of this topical compound agent. As such, the request for Keratek Analgesic Gel 4oz + 3 Refills is not medically necessary.

**Hydrocodone/ APAP/ Ondansetron 5/3002mg #400: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone, Opioids Page(s): 51, 74-95.

**Decision rationale:** The MTUS does not recommend the use of opioids and opioids are not first line medications for musculoskeletal pain. The MTUS recommends a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Opioids have significant side effects and should only be considered for a very short course of treatment according to the MTUS. The treating physician provided no evidence of failed therapy with first line agents such as NSAIDs. The request for Hydrocodone/APAP 10, 325mg #60 is not medically necessary.

