MAXIMUS Federal Services

| Case Number: | CM14-0144148 | | |
|---|---|---|---|
| Date Assigned: | 10/14/2014 | Date of Injury: | 06/01/2013 |
| Decision Date: | 11/24/2014 | UR Denial Date: | 08/07/2014 |
| Priority: | Standard | Application Received: | 09/05/2014 |

## 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 Physical Medicine and Rehabilitation, and is licensed to practice in California. 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:

The underlying date of injury in this case is 6/1/2013. The date of utilization review under appeal is 8/5/2014. The patient's diagnoses include a thoracic sprain, lumbar disc protrusion, lumbar stenosis, and lumbar radiculopathy.A treating physician progress note of 6/30/2014 noted the patient presented with occasional mid-back pain and constant low back pain radiating to the lower extremities. That note indicated that the patient has no gastrointestinal symptoms with the use of medications, and no side effects of oral or topical medications. That note indicates that the patient's pain medication was 9/10 and that topical medications increased sleep and allowed the patient to walk longer and decrease pain. The patient was to continue with an MRI of the lumbar spine to confirm a suspected disc protrusion and continue with a home exercise program as well as cyclobenzaprine, Terocin for muscle pain, Menthoderm as a topical analgesic, Xolido for temporary relief of minor skin irritation, Terocin, Flurbiprofen, Gabacyclotram, Genecin lotion, and Somnacin. The patient also was prescribed multiple medical foods.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of the lumbar spine:** 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), Minnesota Rules, Parameters for medical imagining

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 209.

**Decision rationale:** ACOEM Guidelines, Chapter 12, Low Back, page 209 recommends MRI imaging if there are specific red flags based on neurological examination. The medical records at this time do not clearly provide such a rationale or differential diagnosis for an MRI of the lumbar spine. This request is not supported by the guidelines and I recommend that this be noncertified.

**Xolindo 2% cream:** Upheld

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

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

**Decision rationale:** The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on Topical Analgesics page 111 states that topical medication should only be used with clear documentation of the proposed rationale and mechanism of action. Such details are not documented in this case. Additionally, the component ingredient topical lidocaine is recommended only for localized peripheral neuropathic pain, which is not documented in this case. This request is not medically necessary.

**Menthoderm gel #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111. Decision based on Non-MTUS Citation www.drugs.com/cdi/menthoderm-cream.html

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

**Decision rationale:** The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on Topical Analgesics states regarding topical analgesics that the medical records should document the rationale and proposed mechanism of action of such topical medications. Such details are not present at this time. The medical records and guidelines do not support an indication for Menthoderm. This request is not medically necessary.

**Gabacyclotram 180gms:** Upheld

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

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

**Decision rationale:** The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on Topical Analgesics page 111 states that if any component ingredient in a compounded medication is not recommended, then the overall medication is not recommended. The same guideline specifically does not recommend that the component ingredients gabapentin or cyclobenzaprine for topical use. The records do not provide an alternate rationale for this request. This request is not medically necessary.

**Flurbi (NAP) cream-LA 180gms:** Upheld

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

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

**Decision rationale:** The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on Topical Analgesics states that the use of compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. Such details are not documented at this time. The rationale or indication for this medication is not apparent at this time. This request is not medically necessary.

**Terocin 120mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113. Decision based on Non-MTUS Citation www.drugs.com/pro/terocin.html

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

**Decision rationale:** The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on Topical Analgesics states that the use of compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. Such details are not documented at this time. The rationale or indication for this medication is not apparent at this time. This request is not medically necessary.

**Gabadone #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA Guidance Documents

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

**Decision rationale:** California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines does not discuss medical foods. Official Disability Guidelines/Treatment in Workers Compensation/Pain does state regarding medical foods that the product must be labelled for the dietary management of a specific medical disorder, disease, or condition which has distinctive nutritional requirements. The medical records do not provide such a rationale for Gabadone in this case. This request is not medically necessary.

**Sentra PM #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA Guidance Documents

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

**Decision rationale:** California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines does not discuss medical foods. Official Disability Guidelines/Treatment in Workers Compensation/Pain does state regarding medical foods that the product must be labelled for the dietary management of a specific medical disorder, disease, or condition which has distinctive nutritional requirements. The medical records do not provide such a rationale for Sentra PM in this case. This request is not medically necessary.

**Sentra AM #60:**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA Guidance Documents

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

**Decision rationale:** California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines does not discuss medical foods. Official Disability Guidelines/Treatment in Workers Compensation/Pain does state regarding medical foods that the product must be labelled for the dietary management of a specific medical disorder, disease, or condition which has distinctive nutritional requirements. The medical records do not provide such a rationale for Sentra AM in this case. This request is not medically necessary.

**Theramine #90:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA Guidance Documents

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

**Decision rationale:** California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines does not discuss medical foods. Official Disability Guidelines/Treatment in Workers Compensation/Pain does state regarding medical foods that the product must be labelled for the dietary management of a specific medical disorder, disease, or condition which has distinctive nutritional requirements. The medical records do not provide such a rationale for Theramine in this case. This request is not medically necessary.

**Terocin pain patch #20:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113. Decision based on Non-MTUS Citation www.drugs.com/otc/terocin.html

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

**Decision rationale:** The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on Topical Analgesics states that the use of compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. Such details are not documented at this time. The rationale or indication for this medication is not apparent at this time. This request is not medically necessary.

**Somnicin #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.napharm.com/compound-anxietyinsomia

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

**Decision rationale:** Official Disability Guidelines/Treatment in Workers Compensation/Pain discusses insomnia treatment. This guideline does not recommend pharmacological treatment of insomnia without initial explanation to the cause of such insomnia. Such diagnostic evaluation is not apparent in the current medical records. This request is not medically necessary.

**Genicin #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine and Chondroitin Sulfate Page(s): 50.

**Decision rationale:** California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on glucosamine and chondroitin page 50 states that this treatment is primarily indicated for knee osteoarthritis. It is not clear from the medical records that this is the reason for which Genicin has been recommended. This request is not medically necessary.

**Cyclobenzaprine 10mg #45:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 64.

**Decision rationale:** The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on muscle relaxants states regarding Cyclobenzaprine on page 64 that this is recommended specifically for a short course of therapy only. The medical records do not provide an alternate rationale for utilizing this medication for a more prolonged period of time, or for a chronic condition. This request is not supported by the treatment guidelines. Overall this is not medically necessary.