

<b>Case Number:</b>	CM15-0176002		
<b>Date Assigned:</b>	09/17/2015	<b>Date of Injury:</b>	12/08/2014
<b>Decision Date:</b>	11/06/2015	<b>UR Denial Date:</b>	08/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/08/2015

### 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 63 year old female who sustained an industrial injury on 12-8-2014. A review of medical records indicates the injured worker is being treated for lumbar sprain strain, left knee sprain strain, left ankle injury, and status post-surgery, left ankle. Medical records dated 7-29-2015 noted lumbar spine pain was a 2-3 out of 10 with medication, left knee was 2.5 out of 10 with medication, and left ankle pain a 2 out of 10 with medication. Medical records dated 7-16-2015 rate lumbar spine pain a 4 out 10. Left ankle was rated a 4 out of 10. Physical examination noted 7-29-2015 indicated there was tenderness to palpation of the bilateral SI joints and lumbar paravertebral muscles. There was muscle spasm of the bilateral gluteus and lumbar paravertebral muscles. Straight leg raise was positive. Range of motion was reduced. Left knee flexion was reduced. There was tenderness to palpation of the anterior knee and posterior knee. There was muscle spasm of the anterior knee and posterior knee. There was tenderness to palpation of the anterior ankle and lateral ankle. Treatment has included physical therapy, topical medications, protonix, and Voltaren since at least 4-15-2015. Utilization review dated 8-10-2015 noncertified protonix 20 mg # 60, Voltaren 100 mg #60, topical medications, and outpatient urine toxicology screen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Protonix 20 mg Qty 60:** 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): NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of the requested prescription for this patient. The clinical records submitted do not support the fact that this patient has refractory GERD resistant to H2 blocker therapy or an active h. pylori infection. The California MTUS guidelines address the topic of proton pump prescription. In accordance with California MTUS guidelines, PPIs (Proton Pump Inhibitors) can be utilized if the patient is concomitantly on NSAIDs and if the patient has gastrointestinal risk factors. This patient is not on oral NSAID therapy and topical NSAID therapy is not recommended for chronic pain. Additionally, per the Federal Drug Administration's (FDA) prescribing guidelines for Protonix use, chronic use of a proton pump inhibitor is not recommended due to the risk of developing atrophic gastritis. Short-term GERD symptoms may be controlled effectively with an H2 blocker unless a specific indication for a proton pump inhibitor exists. Therefore, based on the submitted medical documentation, the request for XX prescription is not medically necessary.

**Voltaren 100 mg Qty 60:** 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): NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, GI symptoms & cardiovascular risk, NSAIDs, specific drug list & adverse effects.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. Per the California MTUS guidelines, topical NSAIDs are only recommended for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment." They should only be use for Recommended for "short-term use (4-12 weeks)." Although there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder; Use for neuropathic pain is not recommended as there is no evidence to support use. The medical documentation indicates that this patient has chronic lumbar pain secondary to strain acquired during an industrial accident. Since MTUS does not recommend topical NSAID based analgesics for chronic joint pain, which is not osteoarthritis, induced, the prescription is not indicated. Therefore, based on the submitted medical documentation, the request for diclofenac gel is not medically necessary.

**Compound HMPC1: Amitriptyline HCL (hydrochloride) 10%, Gabapentin 10%. Bupivacaine HCL (hydrochloride) 5%, Hyaluronic Acid 0.2% in cream base, Qty 240 gm: 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:** 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 not recommended as an option for chronic pain control and are largely experimental in use with few randomized control trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended as a whole. The requested cream is a combination of multiple medications including: Amitriptyline HCL (hydrochloride) 10%, Gabapentin 10%. Bupivacaine HCL (hydrochloride) 5%, Hyaluronic Acid 0.2% in a cream base. Compounded medications are not FDA approved or recommended by ODG guidelines due to concerns of purity and efficacy. Hence the request for this compounded medication is not appropriate or indicated by MTUS and ODG guidelines. Therefore, based on the submitted medical documentation, the request for Amitriptyline HCL (hydrochloride) 10%, Gabapentin 10%. Bupivacaine HCL (hydrochloride) 5%, Hyaluronic Acid 0.2% in cream base is not medically necessary.

**Compound HMPC2: Flurbiprofen 20%, Baclofen 510/Dexamethasone 2%, Hyaluronic Acid 0.2% in cream base, Qty 240 gm: 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:** 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 not recommended as an option for chronic pain control and are largely experimental in use with few randomized control trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended as a whole. The requested cream is a combination of multiple medications. Compounded medications are not FDA approved or recommended by ODG guidelines due to concerns of purity and efficacy. Hence the request for this compounded medication is not appropriate or indicated by MTUS and ODG guidelines. Therefore, based on the submitted medical documentation, the request for XX is not medically necessary.

**Urine toxicology screen, outpatient: 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): Drug testing.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of a urine drug screen for this patient. The clinical records submitted do not support the fact that this patient has been documented to have a positive drug screen for illicit or non-prescribed substances. The MTUS guidelines recommend frequent and random urine drug screens where aberrant behavior is suspected. This patient has not been documented to have suspicion of aberrant behavior. His pain is documented as well controlled and his current prescription history is consistent with known prescribed medications. Therefore, based on the submitted medical documentation, the request for drug screening is not-medically necessary.