

<b>Case Number:</b>	CM14-0145197		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	04/22/2010
<b>Decision Date:</b>	11/20/2014	<b>UR Denial Date:</b>	08/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/08/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 injured worker is a 67-year-old female who reported an injury of an unknown mechanism on 04/22/2010. On 06/30/2014, her diagnoses included chronic back pain secondary to a fall, right hip pain secondary to trauma, major depression, and GERD. On 07/03/2014, her medications included Xanax 1 mg, Amitriptyline 50 mg, Gabapentin 400 mg, Norco 7.5/300 mg, and Vytarin 10/10 mg. On 08/06/2014, a progress note's recommendations were for acupuncture, compounded pain relief cream, and to continue her current medications. There was no rationale included in this injured worker's chart. A Request for Authorization dated 08/06/2014 was included.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Acupuncture therapy 3 times weekly for 6 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The request for acupuncture therapy 3 times weekly for 6 weeks is not medically necessary. The California MTUS Guidelines recommend that acupuncture is an option when pain medication is reduced or not tolerated. It may be used as an adjunct to

physical rehabilitation and/or surgical intervention to hasten functional recovery. The recommend frequency of treatments is 1 to 3 times per week with functional improvement noted in 3 to 6 treatments. There was no evidence in the submitted documentation that this injured worker was participating in a physical rehabilitation program or there were any planned surgical interventions. The 18 treatments that were requested exceed the recommendations in the guidelines. Additionally, the body part or parts that were to have been treated were not identified in the request. Therefore, this request for acupuncture therapy 3 times weekly for 6 weeks is not medically necessary.

**Xanax 1mg #540 with 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 Benzodiazepines Page(s): 24.

**Decision rationale:** The request for Xanax 1 mg is not medically necessary. The California MTUS Guidelines do not recommend benzodiazepines for long term use because long term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Tolerance develops in a matter of weeks. The submitted documentation revealed that this injured worker has been using Xanax since 06/30/2014, which exceeds the recommendations in the guidelines. Additionally, there was no quantity or frequency of administration specified. Therefore, this request is not medically necessary.

**Pain formula non-stick day A.M. Lotion to include Ketamine 75%; Cyclobenzaprine 2.25%, EMLA 3.5%, Lidocaine 1.25%, Amitriptyline 1.25%, Diclofenac 3.625%, Baclofen 1%, Dexamethasone 0.2%, in 37.5% Solaraze 3% gel 360g with 1 refill:** Upheld

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

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

**Decision rationale:** The request for pain formula nonstick day AM lotion to include ketamine 75% and Cyclobenzaprine is not medically necessary. The California MTUS Guidelines refer to topical analgesics as largely experimental 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. Many agents are compounded in combination for pain relief, including anesthetics and muscle relaxants. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. There is no evidence for the use of any muscle relaxant as a topical product, including Cyclobenzaprine. Ketamine is under study and only recommended for the treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. Topical ketamine has only been studied

for use in noncontrolled studies for CRPS I and post herpetic neuralgia. There is no evidence that this injured worker has either of the above diagnoses. The guidelines do not support the use of this compounded cream. Therefore, this request for pain formula nonstick day AM lotion to include ketamine 75% and Cyclobenzaprine is not medically necessary.

**Pain /Cervicalgia/Lumbago/ Osteoarthritis P.M Gel to include :Ketamine 3%;Cyclobenzaprine 2% EMLA 7%;Diclofenac 5% (free acid preferred); Dexamethasone 0.4%;Baclofen 2% in PLO 360g with 1 refill: Upheld**

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

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

**Decision rationale:** The request for Pain /Cervicalgia/Lumbago/ Osteoarthritis P.M Gel to include :Ketamine 3%;Cyclobenzaprine 2% EMLA 7%;Diclofenac 5% (free acid preferred); Dexamethasone 0.4%;Baclofen 2% in PLO 360g with 1 refill is not medically necessary. The California MTUS Guidelines refer to topical analgesics as largely experimental with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded in combination for pain control, including NSAIDs, muscle relaxants, and anesthetics. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. The only FDA approved NSAID for topical application is Voltaren gel 1% (Diclofenac). Ketamine is under study. The only recommended use of ketamine is for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. Topical ketamine has only been studied for use in noncontrolled studies for CRPS I and postherpetic neuralgia. There is no evidence for the use of any muscle relaxant as a topical product which would include baclofen and Cyclobenzaprine. The guidelines do not support the use of this compounded medication. Therefore, this request for Pain /Cervicalgia/Lumbago/ Osteoarthritis P.M Gel to include :Ketamine 3%;Cyclobenzaprine 2% EMLA 7%;Diclofenac 5% (free acid preferred); Dexamethasone 0.4%;Baclofen 2% in PLO 360g with 1 refill is not medically necessary.