

Case Number:	CM13-0002002		
Date Assigned:	12/27/2013	Date of Injury:	08/05/1998
Decision Date:	02/20/2014	UR Denial Date:	06/28/2013
Priority:	Standard	Application Received:	07/18/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation 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 physician 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 claimant is a 49 year old female with a date of injury of 8/5/1998. She suffered a right arm injury as a result of repetitive use of her arm at work. Her job basically involved repetitive use of an electrical screw driver. She noticed some pain in her right arm and the next week, the pain had increased significantly. She initially went to [REDACTED] and was diagnosed with tendinitis in her right thumb. She was subsequently seen at [REDACTED] where she was treated with anti-inflammatory medication and physical therapy. She saw her primary care physician who ordered an MRI of her right wrist which was negative. She was then referred to [REDACTED], a hand specialist and an orthopedic surgeon. She then started complaining of right upper extremity pain, neck, and shoulder pain. She was worked up with EMG of Bilateral Upper Extremities on 11/15/2006 which was normal. She was sent to a QME and was told that this was a new injury. Her last cervical epidural steroid injection (CESI) was done on 08/25/2009. Following the CESI, the patient had more than 50% pain relief. She was able to sleep better and had reduced pain in her neck and right upper extremity. She did not feel the need to have another CESI until more recently when she was having increase in her pain. It has been managed mostly with medications since then. Her past treatment includes TENS, PT, cervical epidural steroid injections, acupuncture, and medication management. Review of the documentation reveals that the patient was continuing to undergo treatment for neck pain. She had undergone 2 of her 12 acupuncture sessions with some relief the day of the second treatment. At the time of her exam on 6/21/13, she was currently taking Soma 350 mg, Topiramate-Topamax 25 mg, Trazodone 50 mg, Hydrocodone Bit/APAP, Capsaicin 0.075% cream, and Synovacin-Glucosamine Sulfa 500 mg. She had been taking these medications since at least July of 2012, minus the Capsaicin and Synovacin-Glucosamin

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics Page(s): 65 of 127. Decision based on Non-MTUS Citation Official disability Guidelines

Decision rationale: CA-MTUS (Effective July 18, 2009) page 65, section on Antispasmodics-Carisoprodol (Soma®, Soprodonal 350mg, Vanadom®, generic available) states: Neither of these formulations is recommended for longer than a 2 to 3 week period. Carisoprodol is metabolized to meprobamate an anxiolytic that is a schedule IV controlled substance. Carisoprodol is classified as a schedule IV drug in several states but not on a federal level. It is suggested that its main effect is due to generalized sedation as well as treatment of anxiety. This drug was approved for marketing before the FDA required clinical studies to prove safety and efficacy. Withdrawal symptoms may occur with abrupt discontinuation. (See, 2008) (Reeves, 2003) Side Effects: drowsiness, psychological and physical dependence, & withdrawal with acute discontinuation. MTUS (2009) page 65 of 127. ODG-TWC Pain Procedure Summary last updated 10/14/2013 states that carisoprodol (Soma) is not recommended. This medication is FDA-approved for symptomatic relief of discomfort associated with acute pain in musculoskeletal conditions as an adjunct to rest. Carisoprodol (Soma, Soprodonal350, Vanadom, generic available): Neither of these formulations is recommended for longer than a 2 to 3 week period. Carisoprodol is metabolized to meprobamate an anxiolytic that is a schedule IV controlled substance. Carisoprodol is classified as a schedule IV drug in several states but not on a federal level. It is suggested that its main effect is due to generalized sedation as well as treatment of anxiety. Regarding the present request, Soma does not appear to be necessary in this case. The guidelines state that Soma is not indicated for long-term use. The patient has been taking Soma since at least July of 2012. Since the patient had been taking it for nearly a year, it is not indicated to be continued. Weaning has been recommended in multiple prior reviews. As such, the weaning process should have been completed at this time. Predicated upon the above discussion, the prospective request for the prescription of Soma 350 mg #90 is not medically necessary.

Topiramate-Topamax 25mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topiramate Page(s): 21 of 127.

Decision rationale: CA-MTUS (Effective July 18, 2009) page 21 of 127, states that Topiramate (Topamax®[®], no generic available) has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of "central" etiology. It is still considered for use for neuropathic pain when other anticonvulsants fail. Topiramate has recently been investigated as an adjunct treatment for obesity, but the side effect profile limits its use in this regard. (Rosenstock, 2007) Regarding the request for Topiramate, the evidence based guidelines state that Topamax has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of "central" etiology. It is still considered for use for neuropathic pain when other anticonvulsants fail. The request for Topiramate-Topamax does not appear to be necessary in this case. The guidelines state that Topamax is considered for use for neuropathic pain when other anticonvulsants fail. The patient was taking Gabapentin up until July of 2012, when it was discontinued and Topamax was started. Since starting the Topamax, there has been no significant quantitative subjective or objective improvement in her pain or functioning. Therefore, it is not indicated to continue with this medication. In the prior reviews, weaning has already been recommended and the process should be complete. The prospective request for 1 prescription of Topiramate-Topamax 25 mg #120 is not medically necessary.

Hydrocodone Bit/APAP10/325MG #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76 and 77 of 127.

Decision rationale: CA-MTUS (July 18, 2009) page 76 through 77 of 127, section on Opioids: Norco (hydrocodone (is a semi-synthetic opioid which is considered the most potent oral opioid) and Acetaminophen) is indicated for moderate to moderately severe pain. Results of studies of opioids for musculoskeletal conditions (as opposed to cancer pain) generally recommend short use of opioids for severe cases, not to exceed 2 weeks, and do not support chronic use (MTUS page 82). On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d)

Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to non-opioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. The patient has been on Opioids since

Capsaicin 0.075% cream #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 113 of 127.

Decision rationale: According to CA- MTUS (Effective July 18, 2009) page 113 of 127, section on Topical Analgesics: The use of topical analgesics is largely experimental with few randomized controlled trials to determine efficacy or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006). Regarding the request for Capsaicin, the evidence based guidelines state that Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Topical Capsaicin has moderate to poor efficacy, but may be particularly useful in patients whose pain has not been controlled successfully with conventional therapy. The request for Capsaicin cream is indicated in this case. The patient continued to have pain, but noted that the pain was alleviated with use of topical creams including the Capsaicin. Since the Capsaicin is recommended as an option in patients who have not responded or are intolerant to other treatments, it is appropriate to continue with this treatment. However, guidelines indicate that Capsaicin is generally available as a 0.025% formulation (as a treatment for osteoarthritis) and a 0.075% formulation (primarily studied for post-herpetic neuralgia, diabetic neuropathy and post-mastectomy pain). There have been no studies of a 0.0375% formulation) of capsaicin, and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. The standard 0.025% formulation is indicated for this patient, not the 0.075% formulation. Predicated upon the above discussion, and guidelines cited below, the prospective request for 1 prescription of Capsaicin 0.075% cream #1 is not medically necessary.