

Case Number:	CM13-0002862		
Date Assigned:	12/27/2013	Date of Injury:	07/19/2007
Decision Date:	04/24/2014	UR Denial Date:	07/11/2013
Priority:	Standard	Application Received:	07/24/2013

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, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 patient is a 44-year-old female with a date of injury of 7/19/2007. There are requests for the medical necessity of 1 prescription of Ondansetron HCL 4mg #60, 1 prescription of Tizanidine 4mg #90, 1 prescription of prescription of Terocin pain relief lotion 4oz #1, 1 prescription of Nucynta 100mg #90, and 1 referral to a tertiary pain management center such as [REDACTED] for case review. The patient's diagnoses include: Chronic pain syndrome, chronic regional pain syndrome of the right upper extremity, chronic pain in the neck and right upper extremity and vasomotor changes secondary to right shoulder arthroscopic surgery, myofascial pain syndrome in the bilateral upper back and neck paravertebral musculature.. There is a primary treating physician progress report, dated 11/11/ 13, which states that the patient presents today for a follow-up regarding her right shoulder and bilateral knee pain. She rates her pain today at 8-9/10 on the pain scale. She states she has history of reflex sympathetic dystrophy (RSD). She has ongoing follow-ups with the pain psychologist. She states her knee pain is worse on the medial aspects of her bilateral knees and worse with prolonged standing and walking. On physical examination the right shoulder exam reveals that flexion is 0 to 100', abduction 0 to 100', external rotation 0 to 30', internal rotation 0 to 30°, and adduction and extension 0 to 30'. The patient is tender over the acromioclavicular (AC) joint, with direct palpation and pain in the AC joint with cross-arm testing, positive Speed's test, positive subacromial bursitis, positive drop-arm test, positive impingement, positive O'Brien's, and negative apprehension test. The sensation is hypersensitive in the C5 distribution, 4/5 strength. There is no sign of infection. There is a blue discoloration of her right hand and arm as well, most likely related to RSD. Her right arm is cool to the touch. A left knee exam reveals that flexion is 0° to 130°. There is a positive painful patellofemoral crepitus with motion. A negative Lachman, negative anterior

drawer, negative posterior drawer, stable with varus and valgus stress at 0° and 30°, 2+ popliteal pulse. There is a positive McMurray's testing, creating medial joint pain, No signs of infection or swelling about the knee. No sign of DVT, 4+/5 quad and hamstring strength. The right knee exam revealed that flexion was 0° to 130°. There is painful patellofemoral crepitus with motion, negative Lachman, negative anterior drawer, negative posterior drawer, stable with varus and valgus stress at 0° and 30°, and 2+ popliteal pulses. There is a positive McMurray's testing, creating medial joint pain, with no signs of infection or swelling about the knee. There is no sign of deep vein thrombosis (DVT). There is 4+/5 quad and hamstring strength.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONDANSETRON HCL 4 MG #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (chronic), Ondansetron (Zofran®), Antiemetics (for opioid nausea).

Decision rationale: The Official Disability Guidelines do not recommend odansetron for nausea/vomiting secondary to chronic opioid use. The Guidelines recommend if for the acute use per FDA indications including: chemotherapy and radiation treatment, postoperative use, or acutely used for gastroenteritis. Per documentation, the patient has been prescribed Odansetron for nausea. There is no documentation that this Odansetron is being used postoperatively, for acute gastroenteritis, or secondary to chemotherapy or radiation treatment, therefore, this medication is not medically necessary.

TIZANIDINE 4 MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) and Tizanidine Page(s): 63 and 66.

Decision rationale: The Chronic Pain Guidelines indicate that muscle relaxants can be used as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. The Guidelines also indicate that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. The documentation indicates that the patient has been taking Tizanidine since at least 6/26/2012, with prior utilization reviews recommending weaning this medication. The request for Tizanidine 4mg #90 is not medically necessary or appropriate.

TEROCIN PAIN RELIEF LOTION 4 OZ #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm® (lidocaine patch), Topical Salicylate, and Topical analgesics Page(s): 56-57, 105, 11.

Decision rationale: The Chronic Pain Guidelines indicate that there is little use to support the use of many of these agents. The active ingredients in Terocin Lotion are: Methyl Salicylate 25%, Capsaicin 0.025%, Menthol 10%, and Lidocaine 2.50%. Terocin contains Lidocaine. The guidelines indicate that "Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia." The patient has no documentation that he meets criteria for topical lidocaine and therefore this is not medically necessary. Capsaicin is contained within Terocin, and the guidelines indicate that capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Salicylate topicals are recommended by the guidelines for osteoarthritis and tendinitis in joints that are amenable to topical treatment, but not for use in the spine or neuropathic pain. Topical salicylate is also only recommended for short-term use of four to twelve (4-12) weeks. Terocin contains methyl salicylate. The guidelines do not specifically discuss menthol. There is mention of Ben-Gay which has menthol in it and is medically used for chronic pain, according to the guidelines. Documentation indicates that the patient has been taking Medrox patches (containing topical salicylate) since at least 5/17/2013, and was prescribed Terocin lotion on 6/26/2012, which would exceed the guideline recommendations of the duration of use. The guidelines also indicate that any compounded product that contains at least one (1) drug (or drug class) that is not recommended is not recommended. The request for Terocin pain relief lotion 4 oz #1 is not medically necessary.

NUCYNTA 100 MG #90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, When to discontinue opioids, Page(s): 79.

Decision rationale: The Chronic Pain Guidelines indicate that opioids should be discontinued without any resolution of pain or improvement in function. The Official Disability Guidelines indicate that Nucynta (tapentadol) is a second line therapy for patients who have intolerable adverse effects with first line opioids. According to the documentation, the patient has been on Nucynta since at least 6/26/12, without significant functional improvement or significant improvement in analgesia. There have been prior utilization reviews recommending weaning this medication. Additionally per documentation, dated 3/13/13, the treating physician stated that the Nucynta should be titrated until the patient is off of the medication, due to no significant

improvement in analgesia. Therefore the request of one (1) prescription for Nucynta 100mg #90 is non-certified.

ONE (1) REFERRAL TO A TERTIARY PAIN MANAGEMENT CENTER, SUCH AS [REDACTED] FOR A CASE REVIEW: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 30-32.

Decision rationale: On a 5/6/13 Agreed Medical Evaluation (AME), the physician performing the AME felt that it was very reasonable to have the patient seen at the [REDACTED] outpatient pain management program to review her situation and make sure that her care is optimized. There is documentation that the patient prefers not to take multiple medications. There is also documentation that patient has had multiple treatments without significant clinical or functional improvement. The request as written is not clear whether this program at [REDACTED] is inpatient or outpatient. There is no documentation submitted revealing evidence that the patient cannot participate in an outpatient program. There is no documentation that the patient is motivated to return to work. The request for a referral to a tertiary pain management center such as [REDACTED] for case review is not medically necessary.