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| Case Number: | CM13-0023383 | | |
| Date Assigned: | 12/11/2013 | Date of Injury: | 06/18/1998 |
| Decision Date: | 04/18/2014 | UR Denial Date: | 08/12/2013 |
| Priority: | Standard | Application Received: | 09/12/2013 |

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 Family Practice, and is licensed to practice in Arizona. 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 58-year-old female with a date of injury of 6/18/98. The patient has been treated for ongoing symptoms in her neck, back, shoulder, and knees. Her diagnoses include cervical and lumbar sprain, rotator cuff syndrome, and internal derangement of knees. Subjective complaints are of neck pain with radiation and numbness/tingling to both hands. Pain is reported in both knees and shoulder. Physical exam shows decreased lumbar and cervical range of motion, with tenderness to neck, shoulder, and knees. Shoulder motion is described as being full in some exams and limited in others. There is no documentation of shoulder impingement tests indicative of rotator cuff pathology. The patient has had previous rotator cuff surgery. MRI of the shoulder shows post surgical changes and a recurrent tear without retraction. Medications include valium 10mg, Norco 10/325mg as needed, and Terocin lotion. Previous conservative measures have included acupuncture in 2012. There is no recent documentation of physical therapy or other conservative measures. Submitted documentation shows multiple denials of surgery due to no information regarding previous surgery and no record of previous conservative treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF VALIUM 10MG ONE TO TWO (1-2) Q6-8HR #60 X 4 REFILLS:

Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 401, Chronic Pain Treatment Guidelines Page(s): 24.

Decision rationale: The California MTUS guidelines do not recommend anxiolytics as first-line therapy for stress-related conditions as they can lead to dependence and do not alter stressors or the individual's coping mechanisms. Benzodiazepines in particular are not recommended for long-term use because long-term efficacy is unproven. Most guidelines limit use to four weeks, due to dependence and tolerance that can occur within weeks. The ongoing treatment with Valium was not supported by documentation, there was no evidence of functional improvement, and no long-term plan to substitute or wean from this medication was established. Due to these reasons, the medical necessity of valium is not established.

PRESCRIPTION OF NORCO 10/325MG ONE TO TWO (1-2) EVERY FOUR TO SIX (4-6) HOURS PRN #120 X 4 REFILLS: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76,80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74,96.

Decision rationale: The patient in question has been on chronic opioid therapy. The California Chronic Pain Medical Treatment Guidelines have specific recommendations for the ongoing management of opioid therapy. Clear evidence should be presented about the degree of analgesia, level of activity of daily living, adverse side effects, or aberrant drug taking behavior. For this patient, documentation shows stability on medication, increased functional ability, and no adverse side effects. Furthermore, documentation of MTUS opioid compliance guidelines, including updated urine drug screen, and ongoing efficacy of medication is present. Therefore, the use of this medication is consistent with guidelines and is medically necessary for this patient.

PRESCRIPTION OF TERODOLOCIN (TEROCIN LOTION) 120MG: 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 Page(s): 56, 111-113.

Decision rationale: Terocin is a compounded medication that includes methyl salicylate, menthol, lidocaine, and capsaicin. The California Chronic Pain Medical Treatment Guidelines are clear that if a medication contains one drug or drug class within a compounded medication is not recommended, then the entire product should not be recommended. Topical lidocaine in the

form of Lidoderm may be recommended for localized peripheral pain, but no other commercially approved topical formulations of lidocaine are indicated. While capsaicin has some positive results in treating osteoarthritis, fibromyalgia, and non-specific back pain, it has shown moderate to poor efficacy. Topical salicylates have been demonstrated as superior to placebo for chronic pain to joints amenable to topical treatment. The menthol component of this medication has no specific guidelines or recommendations for its indication or effectiveness. In addition to capsaicin and menthol not being supported for use in this patient's pain, the medical records do not indicate the anatomical area for it to be applied. As such, the requested prescription is not medically necessary.

PRESCRIPTION OF FLURBIPROFEN 25% TOPICAL CREAM 30GM: Overturned

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 Page(s): 111-113. Decision based on Non-MTUS Citation the Official Disability Guidelines.

Decision rationale: The California MTUS indicates that topical non-steroidal anti-inflammatory drugs (NSAIDs) have been shown in meta-analysis to be superior to placebo during the first two weeks of treatment for osteoarthritis, but with a diminishing effect over another two-week period. The California MTUS also indicates that topical NSAIDs are not recommended for neuropathic pain, as there is no evidence to support their use. They are indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). The Official Disability Guidelines states that when investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4-12 weeks. The patient has bilateral knee pain. This joint is amenable to topical NSAID treatment. Therefore, the requested Flurbiprofen topical cream is medically necessary.

PRESCRIPTION OF FLURBIPROFEN 25%- LIDOCAINE 5%, CYCLOBENZAPRINE 10%- TRAMADOL 10% 30GM: 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 Page(s): 56, 111-113.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines are clear that if a medication contains one drug or drug class within a compounded medication is not recommended, then the entire product should not be recommended. This product combines Flurbiprofen, lidocaine, Cyclobenzaprine, and Tramadol. Guidelines do not recommend topical Cyclobenzaprine, as no peer-reviewed literature supports their use. Furthermore, muscle relaxers in general show no benefit beyond non-steroidal anti-inflammatory drug (NSAIDs) in pain reduction. Lidocaine is only recommended as a dermal patch. No other commercially approved topical formulations of lidocaine are indicated. Furthermore, the medical record does not indicate

the location for this medication to be used. Therefore, the medical necessity of this compounded medication is not established.

RIGHT SHOULDER SURGERY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

Decision rationale: The Official Disability Guidelines has specific indications for rotator cuff surgery. Criteria for rotator cuff repair include first ruling out cervical pathology and frozen shoulder syndrome. Subjective and objective evidence of rotator cuff injury should be present, and imaging studies should evidence of deficit in the rotator cuff. Also, 3-6 months of conservative care should be documented as failing before proceeding with surgery. This patient, while having evidence of pathology on MRI, does not have documented consistent subjective and objective findings, and does not have records detailing her prior surgical intervention. In addition, there is no documentation detailing patient's prior conservative treatments. Therefore, the medical necessity of rotator cuff surgery is not established.