MAXIMUS Federal Services

| Case Number: | CM13-0029230 | | |
|---|---|---|---|
| Date Assigned: | 03/19/2014 | Date of Injury: | 12/17/2011 |
| Decision Date: | 05/09/2014 | UR Denial Date: | 09/20/2013 |
| Priority: | Standard | Application Received: | 09/25/2013 |

## 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 & Rehabilitation, has a subspecialty in Sports Medicine and is licensed to practice in Texas. 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 41-year-old female who reported an injury on 12/17/2011. The mechanism of injury was not provided in the medical records. The injured worker's initial course of treatment is unclear; however, it was noted that she received a left shoulder decompression in approximately 09/2012. In mid-2013, the injured worker received a course of 12 sessions of physical therapy for left shoulder stiffness and weakness; however, due to the failure of symptoms to resolve, she was referred for further testing. The injured worker received an EMG/NCV of the bilateral upper extremities on 06/18/2013. This study revealed no abnormalities. Additionally, the injured worker received an MRI of the left shoulder on 06/25/2013 that revealed moderate cuff tendinopathy, focal fraying of the posterior superior labrum, glenohumeral capsulitis, possibly a case of adhesive capsulitis, and modest degeneration of the AC joint. The injured worker also has history of postsurgical cortisone injections and uses multiple medications. The injured worker performs a home exercise program, to include Zumba, utilizes TENS therapy, and hot/cold therapy. There was no other information submitted for review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**FLEXERIL 7.5MG #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain)..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-64.

**Decision rationale:** The California MTUS Chronic Pain Guidelines recommend non-sedating muscle relaxants as a second line option for the short-term treatment of acute exacerbations of muscle spasms. Flexeril in particular, is an antispasmodic that is not recommended for use longer than 3 weeks. The clinical information submitted for review provided evidence that the injured worker has been utilizing Flexeril since at least 05/30/2013; however, none of the physical examination findings included the presence of muscle spasms. As the injured worker's length of use of this medication far exceeds the guideline recommendations of 3 weeks, and there was no presence of muscle spasms found on any of the physical examinations, continued use of this medication is not indicated. As such, the request for Flexeril 7.5 mg #60 is non-certified.

**TRAMADOL ER 150MG #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

**Decision rationale:** The California MTUS/ACOEM Guidelines recommend opioids to treat moderate to severe chronic pain. The guidelines state that ongoing management of opioid treatment includes obtaining functional measurements at 6 month intervals, conducting a thorough pain assessment at each clinical visit, and utilizing random urine drug screens. The clinical information submitted for review did not provide any functional measurements, pain levels, or evidence of urine drug screens. Without this information, evidence of medication efficacy cannot be determined. As such, the request for tramadol ER 150 mg #30 is non-certified.

**PRILOSEC 20MG #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 68-69.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68.

**Decision rationale:** The California MTUS/ACOEM Guidelines recommend using proton pump inhibitors for patients at high risk for gastrointestinal events. Risk factors include being over the age of 65; history of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, or anticoagulants; or high dose/multiple use of NSAIDs. The clinical information submitted for review did not provide any evidence that the injured worker had any of these risk factors; she is under the age of 65, there was no documentation of prior gastrointestinal dysfunction, and she is not currently utilizing any NSAIDs. As such, the medical necessity for

continued use of this medication has not been established, and the request for Prilosec 20 mg #60 is non-certified.

**TEROCIN LOTION:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 113.

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

**Decision rationale:** The California MTUS/ACOEM Guidelines recommend topical analgesics to treat primarily osteoarthritic or neuropathic pain. Terocin lotion is a formulation of methyl salicylate 25%, Capsaicin 0.025%, menthol 10%, and Lidocaine 2.50%. Guidelines state that any compounded product containing at least 1 drug or drug class that is not recommended, deems the entire product not recommended. As guidelines only support the use of Lidocaine in a dermal patch formulation for the treatment of neuropathic pain, and does not support Lidocaine in a cream, lotion, or gel formulation, this medication is not supported by guidelines. Furthermore, there is no evidence of objective findings of neuropathy that would necessitate the use of a topical analgesic such as Lidocaine. As such, the request for Terocin lotion is non-certified.

**TEROCIN PATCH #20:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS, 111-113

**Decision rationale:** The California MTUS/ACOEM Guidelines recommend topical analgesics to treat primarily osteoarthritic or neuropathic pain. Terocin patches are a formulation of methyl salicylate 25%, Capsaicin 0.025%, menthol 10%, and Lidocaine 2.50%. Guidelines state that any compounded product containing at least 1 drug or drug class that is not recommended, deems the entire product not recommended. Furthermore, there is no indication of objective findings of neuropathy that would necessitate the use of a topical analgesic such as Lidocaine. As such, the request for Terocin patch #20 is non-certified.

**REMERON 15MG #30:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.drugs.com/pro/mirtazapine.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Insomnia Treamtent.

**Decision rationale:** The California MTUS/ACOEM Guidelines do not address the treatment for insomnia; therefore, the Official Disability Guidelines were supplemented. ODG recommends sedating antidepressants such as mirtazapine (Remeron) as an option, in the treat of insomnia. The clinical information submitted for review indicated that the injured worker had previously been utilizing Acetadryl for insomnia, and that the Remeron was initially prescribed in 09/2013. As this is a new prescription and is an appropriate treatment for insomnia, continuation of this medication is indicated, at this time. As such, the request for Remeron 15 mg #30 is certified