

<b>Case Number:</b>	CM13-0029799		
<b>Date Assigned:</b>	11/27/2013	<b>Date of Injury:</b>	01/02/2011
<b>Decision Date:</b>	10/21/2014	<b>UR Denial Date:</b>	08/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	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 and Rehabilitation and is licensed to practice in Nevada. 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 records presented for review indicate that this 23 year old female was reportedly injured on January 2, 2011. The most recent progress note, dated August 8, 2013, indicates that there were ongoing complaints of left wrist pain back pain. The physical examination demonstrated reduced grip strength and reduced sensation the ulnar nerve distribution, spine shows tenderness to palpation to the paravertebral muscles of the thoracic and lumbar spine, spasm, reproducible pain with pressure, and positive straight leg raise test on the right. Diagnostic imaging studies were not included for review. Previous treatment includes use of a transcutaneous electrical nerve stimulation (TENS) unit, a lumbar corset, ice, and multiple medications. A request was made for Medrox pain relief ointment, Ketoprofen 75 milligrams daily quantity thirty, Omeprazole delayed release (DR) 20 milligrams one daily quantity thirty, Orphenadrine extended release (ER) 100 milligrams twice daily quantity sixty, and for Tramadol HCL 50 milligrams twice daily quantity sixty, and was denied in the preauthorization process on 8/27/13.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RETROSPECTIVE REQUEST FOR MEDROX PAIN RELIEF OINTMENT, DISPENSED 08/08/2013: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL COMPOUNDED ANALGESICS.

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

**Decision rationale:** MTUS guidelines state that Topical Analgesics are largely experimental and that any compound product that contains at least one drug (or drug class) that is not recommended is not recommended. Additionally, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The clinician fails to document a diagnosis that would indicate that this medication is necessary. Furthermore, the MTUS supports the use of capsaicin for individuals who are intolerant to other treatments for the management of osteoarthritis, postherpetic neuralgia, diabetic neuropathy, and/or postmastectomy pain. Based on the clinical documentation provided, claimant fails to meet criteria as outlined by the MTUS. Specifically, there is no documented diagnosis that would indicate use of such medication and no mention of where the medication will be applied. As such, the request is considered not medically necessary.

**RETROSPECTIVE REQUEST FOR KETOPROFEN 75MG, ONE DAILY, QUANTITY: 30, DISPENSED 08/08/2013:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22 of 127..

**Decision rationale:** The MTUS supports the use of anti-inflammatories as a first line of treatment, to reduce pain so activity and functional restoration can resume, but long term use may not be warranted. According to the medical records, there is no reported decrease pain and increased functional activity related directly to the use of medication. Therefore, this request for Ketoprofen is not medically necessary.

**RETROSPECTIVE REQUEST FOR OMEPRAZOLE DR 20MG, ONE DAILY, QUANTITY: 30, DISPENSED 08/08/2013:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines DIVERSE SIDE EFFECTS AND PROTON PUMP INHIBITORS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

**Decision rationale:** MTUS guidelines support the use of proton pump inhibitors (PPI) in patients taking nonsteroidal antiinflammatory medications with documented gastroesophageal distress symptoms and/or significant risk factors. Long term PPI use (greater than one year) has been shown to increase the risk of hip fractures. Review of the available medical records, fails to document any signs or symptoms of GI distress which would require PPI treatment. As such, this request is not considered medically necessary.

**RETROSPECTIVE REQUEST FOR ORPHENADRINE ER 100MG, TWICE DAILY, QUANTITY: 60, DISPENSED 08/08/2013: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

**Decision rationale:** Orphenadrine is a derivative of Diphenhydramine and belongs to a family of antihistamines. It is used to treat painful muscle spasms and Parkinson's. The combination of anticholinergic effects and CNS penetration make it very useful for pain of all etiologies including radiculopathy, muscle pain, neuropathic pain and various types of headaches. It is also useful as an alternative to gabapentin for those who are intolerant of the gabapentin side effects. This medication has abuse potential due to a reported euphoric and mood elevating effect, and therefore should be used with caution as a second line option for short term use in both acute and chronic low back pain. Based on the clinical documentation provided, the clinician does not document trials of any previous anticonvulsant medications or medications for chronic pain such as Gabapentin. Given the MTUS recommendations that this be utilized as a second line agent, the request is deemed not medically necessary.

**TRAMADOL HCL 50MG, TWICE DAILY, QUANTITY: 60, DISPENSED 08/08/2013: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS - WHEN TO CONTINUE, WHEN TO DISCONTINUE, WEANING, URINE DR.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82, 113 of 127..

**Decision rationale:** MTUS treatment guidelines support the use of Tramadol (Ultram) for short term use after there is been evidence of failure of a first line option, evidence of moderate to severe pain, and documentation of improvement in function with the medication. Given their clinical presentation and lack of documentation of functional improvement with Tramadol, as well as lack of documentation of failure of a first line option, the request is not considered medically necessary.