

<b>Case Number:</b>	CM13-0032864		
<b>Date Assigned:</b>	12/06/2013	<b>Date of Injury:</b>	10/23/2006
<b>Decision Date:</b>	02/20/2014	<b>UR Denial Date:</b>	09/24/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/08/2013

### 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 Physical Medicine & Rehabilitation 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 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 patient is a 63-year-old female who reported an injury on 10/23/2006. The mechanism of injury was not provided for review. The patient developed chronic neck pain radiating into the bilateral upper extremities. Her treatments included physical therapy, acupuncture, epidural steroid injections, trigger point injections, biofeedback, psychiatric support, cervical traction, and medications. The patient's clinical findings on 09/06/2013 included tenderness and spasming of the bilateral cervical paraspinal musculature and upper trapezius and middle trapezius muscles. The patient had tenderness to palpation of the left elbow and proximal forearm in the lateral epicondyle area. The patient's medications included Soma, Percocet, ketoprofen ointment, Neurontin, Lidoderm, Prilosec, and intermezzo. The patient's diagnoses included chronic neck pain, cervical radiculopathy, and PTSD. The patient's treatment plan included continuation of medications, cervical spinal nerve blocks, and continuation of cervical traction use.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro Ketoprofen/Capsaicin/Cyclobenzaprine ointment for topical pain/inflammation dispensed 9/6/13: Upheld**

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

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

**Decision rationale:** The MTUS Chronic Pain Guidelines do not recommend the use of Ketoprofen as it is not FDA approved as a topical agent. The Guidelines also do not recommend the use of capsaicin unless there is documentation that the patient has failed to respond to first line treatments. The clinical documentation submitted for review does not provide any evidence that the patient has failed to respond to a trial of anticonvulsants or antidepressants. The California Medical Treatment and Utilization Schedule does not recommend the use of muscle relaxants as topical agents as there is not enough scientific evidence to support the efficacy of these types of agents. The California Medical Treatment and Utilization Schedule states that any compounded medication that contains at least 1 drug or drug class that is not recommended by Guideline recommendations is not supported. As such, the retrospective request for Ketoprofen/Capsaicin/Cyclobenzaprine ointment for topical pain/inflammation dispensed 9/6/13 is not medically necessary or appropriate.

**Retro Soma 350mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 29, 65.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines section on Muscle Relaxants Page(s): s 63-66.

**Decision rationale:** The MTUS Chronic Pain Guidelines do not support the long-term use of this medication as there is a high risk of physical and psychological dependence. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration. The MTUS Chronic Pain Guidelines indicate the use of this medication for acute exacerbations of muscle spasming should be limited to 3 to 4 weeks. As the patient has been on this medication for an extended duration, continued use would not be supported. As such, the request for Retro Soma 350mg q4-6 #120 is not medically necessary and appropriate.

**Retro Percocet 7.51325 mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 79-81.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines section on Opioids Page(s): 78.

**Decision rationale:** The MTUS Chronic Pain Guidelines recommend the continued use of opioids be supported by a quantitative assessment of pain relief, documentation of significant functional benefit, managed side effects, and monitoring for aberrant behavior. The clinical documentation submitted for review does provide evidence that the patient is monitored for aberrant behavior with urine drug screens. However, there was no quantitative assessment of

pain relief or documentation of functional benefit as it is related to this medication. As such, the retrospective request for Percocet 7.51325 mg #90 dispensed 9/6/13 is not medically necessary and appropriate.

**Retro Prilosec 20mg dispensed 9/6/13: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (Pain Chapter)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines section on NSAIDS, GI symptoms & cardiovascular risk Page(s): 68.

**Decision rationale:** The MTUS Chronic Pain Guidelines recommend a gastrointestinal protectant for patients at risk for developing gastrointestinal disturbances related to medication usage. The clinical documentation submitted for review does indicate that the patient has GI upset with medication usage. However, an adequate assessment of the patient's gastrointestinal system was not provided to support the continued use of this medication. As such, the retrospective request for Prilosec 20mg BID dispensed 9/6/13 is not medically necessary and appropriate.

**Retro Lidoderm dispensed 9/6/13: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 56-57.

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

**Decision rationale:** The MTUS Chronic Pain Guidelines recommend continued use of Lidoderm as a topical analgesic is supported by continued functional benefit and pain relief. The clinical documentation submitted for review does not provide a quantitative assessment of pain relief or documentation of increased functional benefit related to this medication. As such, the retrospective request for Lidoderm 9/6/13 is not medically necessary and appropriate.

**Retro Intermezzo 3.5mg dispensed 9/6/13: 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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Chapter, section on Zolpidem.

**Decision rationale:** The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration. It is also noted that this

medication "continues to help greatly in regards to sleep." The Official Disability Guidelines recommend the continued use of this type of medication be based on documented improvements in the patient's sleep hygiene. The clinical documentation submitted for review does not provide an adequate assessment of the patient's sleep habits to support that this medication is providing sufficient relief for this patient. Therefore, continued use would not be indicated. As such, the retrospective request for Intermezzo 3.5mg dispensed 9/6/13 is not medically necessary and appropriate

**Retro Toradol spray #5 1.7g bottles dispensed 9/6/13: 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.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Chapter, section on Sprix (ketorolac tromethamine nasal Spray).

**Decision rationale:** The clinical documentation submitted for review does provide evidence that the patient has chronic cervical spine pain. The Official Disability Guidelines do not recommend the use of this medication as a first line treatment. It is noted within the documentation that this medication is to be used for exacerbations or pain flare-ups. There is no documentation that the patient has failed to respond to first line treatments for acute exacerbations of the patient's chronic pain. As such, the retrospective request for Toradol spray #5- 1.7g bottles dispensed 9/6/13 is not medically necessary and appropriate.