

Case Number:	CM13-0049973		
Date Assigned:	12/27/2013	Date of Injury:	04/06/2010
Decision Date:	03/12/2014	UR Denial Date:	10/10/2013
Priority:	Standard	Application Received:	11/08/2013

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 Internal Medicine and Emergency Medicine and is licensed to practice in Florida. 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:

This patient is a 39-year-old with a date of injury of 04/08. A progress report associated with the request for services, dated 09/25/13, identified subjective complaints of pain and discomfort in the left hand. There was also pain in the right wrist. Objective findings included tenderness of both lateral elbows and decreased sensation in the median nerve distribution bilaterally. Previous nerve conduction studies on 08/03/10 were normal. Diagnoses included bilateral carpal tunnel syndrome and bilateral epicondylitis. Treatment has included oral analgesics for several months. A Utilization Review determination was rendered on 10/10/13 recommending non-certification of "Hand therapy 3 x 4 on the right hand; Hydrocodone (Norco APAP_ 10/325 mg #60; orphenadrine ER 100mg #60; capsaicin 0.075% cream; Biofreeze with gel 0.2-3.5%".

IMR ISSUES, DECISIONS AND RATIONALES

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

Hand therapy three (3) times a week for four (4) weeks on the right: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The Chronic Pain Guidelines recommend physical therapy with fading of treatment frequency associated with "... active therapies at home as an extension of the treatment process in order to maintain improvement levels." Specifically, for myalgia and myositis, nine to ten (9-10) visits over eight (8) weeks. For neuralgia, neuritis, and radiculitis, eight to ten (8-10) visits over four (4) weeks. In this case, the patient has not received prior physical therapy of the right hand. However, recommendations are for less than twelve (12) sessions, with the recommendation for fading of treatment frequency. Likewise, there is limited documentation for the home therapy component of this approach. Therefore, the record does not document the medical necessity for twelve (12) sessions of hand physical therapy.

Hydrocodone (Norco APAP) 10/325 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids Page(s): 76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-82. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Opioids for Chronic Pain.

Decision rationale: Norco 10/325 is a combination drug containing acetaminophen and the opioid hydrocodone. The Chronic Pain Guidelines related to on-going treatment of opioids state that there should be documentation and ongoing review of pain relief, functional status, appropriate use, and side effects. The pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid. The guidelines also state that there should be documentation and ongoing review of pain relief, functional status, appropriate use, and side effects. The guidelines note that a recent epidemiologic study found that opioid treatment for chronic non-malignant pain did not seem to fulfill any of the key outcome goals including pain relief, improved quality of life, and/or improved functional capacity. The Chronic Pain Guidelines also state that with chronic low back pain, opioid therapy "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (> 16 weeks), but also appears limited." Additionally, "There is also no evidence that opioids showed long-term benefit or improvement in function when used as treatment for chronic back pain." The Official Disability Guidelines state, "While long-term opioid therapy may benefit some patients with severe suffering that has been refractory to other medical and psychological treatments, it is not generally effective achieving the original goals of complete pain relief and functional restoration." Therapy with Norco appears to be ongoing. The documentation submitted lacked a number of the elements listed above, including the level of functional improvement afforded by the chronic opioid therapy. Therefore, the record does not demonstrate medical necessity for Norco.

Orphenadrine ER 100mg #60:

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain). Page(s): 63-66.

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

Decision rationale: Orphenadrine (Norflex) is a muscle relaxant with anticholinergic side effects. The Chronic Pain Guidelines state that non-sedating muscle relaxants are recommended for short-term treatment of acute exacerbations in patients with chronic low back pain. Its mechanism of action is not clearly understood, but may be secondary to analgesic and anticholinergic properties. It is sometimes abused for the above mentioned effects. Based on the indications noted above, there is no documented medical necessity for orphenadrine.

Capsaicin 0.075% cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Decision rationale: The Chronic Pain Guidelines state that topical analgesics are largely experimental and are primarily recommended for neuropathic pain. The Guidelines also state that capsaicin topical is "Recommended only as an option in patients who have not responded or are intolerant to other treatments." It is noted that there are positive randomized trials with capsaicin cream in patients with osteoarthritis, fibromyalgia, and chronic non-specific low back pain, but it should be considered experimental at very high doses. The Guidelines further note that although capsaicin has moderate to poor efficacy, it may be particularly useful (alone or in combination with other modalities) in patients whose pain has not been controlled successfully with conventional therapy. The Official Disability Guidelines (ODG) state that neither salicylates nor capsaicin have shown efficacy in the treatment of osteoarthritis. Capsaicin is available as a 0.025% formulation (for the treatment of osteoarthritis) and a 0.075% formulation primarily from studies for neuropathic pain. However, the Guidelines specifically state that: "... there have been no studies of 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy." This patient has not been diagnosed with neuropathic pain that would warrant a 0.075% concentration of capsaicin. Considering its moderate to poor efficacy, there is no documentation of the failure of conventional therapy for the medical necessity of capsaicin topical.

Biofreeze with gel 0.2-3.5%: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Biofreeze cryotherapy gel, and www.biofreeze.com.

Decision rationale: Biofreeze is a topical form of cryotherapy with the active ingredient, menthol. The Chronic Pain Guidelines do not specifically address menthol as a topical analgesic. However, at-home applications of local heat or cold to the elbow for comfort are recommended, and for the wrist optional. The Official Disability Guidelines indicate that Biofreeze is recommended as an optional form of cryotherapy for acute pain. Studies on acute low back pain showed significant pain reduction after each week of treatment. There is no recommendation related to the use of Biofreeze for chronic pain. The original denial of services was not based on Biofreeze as cryotherapy. In view of the optional recommendation for the treatment of wrist and elbow with cryotherapy as well as the recommendation for Biofreeze in acute low back pain, there is documented medical necessity in this case for topical Biofreeze.