

Case Number:	CM13-0065444		
Date Assigned:	01/15/2014	Date of Injury:	03/06/2008
Decision Date:	05/20/2014	UR Denial Date:	11/27/2013
Priority:	Standard	Application Received:	12/13/2013

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 has a subspecialty in Interventional Spine and is licensed to practice in California. 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 53-year-old male with a date of injury of 03/06/2008. The listed diagnoses are: (1) Radial nerve lesion, (2) Impingement syndrome, shoulder, (3) Unspecified disorder of joint/shoulder region, (4) Fracture, radius/ulna shaft. According to a handwritten progress report dated 10/18/2013 by [REDACTED], the patient complains of mild shoulder pain and right wrist pain. Objective findings include right shoulder shows well-healed incision. Right wrist is positive for numbness. This is the extent of the report and physical examination reporting. Four other progress reports are provided for review, all with limited clinical impression.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF NORCO 10/325MG #120 (WITH 2 REFILLS): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC OPIATE USE Page(s): 88-89.

Decision rationale: This patient presents with right shoulder pain. The treater is requesting Norco 10/325 mg #120 with 2 refills. For chronic opiate use, the MTUS Guidelines page 88 and

89 require functioning documentation using a numerical scale or a validated instrument at least once every six months. Documentation of the 4A (analgesia, ADLs, adverse side effects, and adverse behavior) are required. Furthermore under outcome measure, MTUS states, "Measures of pain assessment that allow for evaluation of the efficacy of opioids and whether their use should be maintained include the following: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts." Medical records indicate the patient has been taking this medication since at least 07/03/2013, possibly early as this is the earliest report provided for review. Review of reports from 07/03/2013 to 10/18/2013 does not provide any discussions regarding whether or not Norco has provided any pain relief or functional improvements. There are no discussions regarding significant changes in ADL's, or return to work due to opiate use. In addition, the treater does not use a numerical scale to assess patient's pain as required by MTUS. Given the lack of sufficient documentation warranting long term opiate use, the patient should slowly be weaned off of Norco as outlined in MTUS Guidelines. Recommendation is for denial.

PRESCRIPTION OF ULTRAM 50MG, #60 (WITH 2 REFILLS): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 76-78.

Decision rationale: This patient presents with right shoulder pain. The treater is requesting Ultram 50 mg #60 with 2 refills. The MTUS guidelines pg 76-78, criteria for initiating opioids recommends that reasonable alternatives have been tried, consider patient's likelihood of improvement, likelihood of abuse, etc. MTUS goes on to state that baseline pain and functional assessments should be made. Once the criteria have been met a new course of opioids may be tried at that time. In this case, the treater does not provide baseline pain or any functional assessments to necessitate a start of a new opioid. In addition, the patient is already on Norco and the treater does not discuss how Norco is or is not working, making it unclear as to why another opioid is being initiated at this time. The requested Ultram is not medically necessary and recommendation is for denial.

PRESCRIPTION OF SOMA 350MG, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CARISOPRODOL (SOMA)..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS Page(s): 63.

Decision rationale: This patient presents with right shoulder pain. The treater is requesting Soma 350 mg #60. The MTUS Guidelines page 63 regarding muscle relaxants states, "Recommended non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exasperations in patients with chronic LBP. Muscle relaxants may be

effective in reducing pain and muscle tension and increasing mobility; however, in most LBP cases, they showed no benefit beyond NSAIDs and pain with overall improvement. Efficacy appears to diminish over time, and prolonged use of some medication in this class may lead to dependence." The treater is requesting #60 Soma and muscle relaxants are recommended for short-term use only. Recommendation is for denial.

PRESCRIPTION OF KETO FLEX CREAM 30GR/120GR: 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. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS, PAGE 111

Decision rationale: This patient presents with right shoulder pain. The treater is requesting Keto-Flex cream 30 g. The MTUS Guidelines p 111 has the following regarding topical creams, "topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety." MTUS further states, "Any compounded product that contains at least one (or drug class) that is not recommended is not recommended." The MTUS Guidelines page 111 supports the use of topical NSAIDs for peripheral joint arthritis or tendonitis; however, non-FDA approved agents like Ketaprofen is not recommended for any topical use. MTUS further states this agent is not currently FDA approved for a topical application. "It has an extremely high incidence of photocontact dermatitis." Recommendation is for denial.

PRESCRIPTION OF FLUR MILD CREAM 30GR/120GR: 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. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS, PAGE 111

Decision rationale: This patient presents with right shoulder pain. The treater is requesting Flur mild cream. MTUS has the following regarding topical creams (p111, chronic pain section): "Non-steroidal antiinflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis. Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment." This patient does not meet the indication for this topical medication as he does not present with any osteoarthritis or tendinitis of a peripheral joint. The requested Flurbiprofen gel is not medically necessary and recommendation is for denial.

PRESCRIPTION OF MEDROX CREAM 120GR: 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 CREAMS Page(s): 111.

Decision rationale: This patient presents with right shoulder pain. The treater is requesting Medrox cream 120 g. The MTUS, ACOEM, and ODG Guidelines do not discuss Medrox ointment specifically. The MTUS Guidelines p 111 has the following regarding topical creams, "topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety." MTUS further states, "Any compounded product that contains at least one (or drug class) that is not recommended is not recommended." Medrox is a compound topical analgesic including methyl salicylate 20%, menthol 7%, and capsaicin 0.050%. The MTUS Guidelines allows capsaicin for chronic pain conditions such as fibromyalgia, osteoarthritis, and nonspecific low back pain. However, MTUS considers doses that are higher than 0.025% to be experimental, particularly at high doses. Medrox ointment contains 0.050% of capsaicin which is not supported by MTUS Guidelines. Therefore, the entire compound ointment is not recommended.