

Case Number:	CM14-0105911		
Date Assigned:	08/01/2014	Date of Injury:	04/02/1999
Decision Date:	09/10/2014	UR Denial Date:	06/10/2014
Priority:	Standard	Application Received:	07/09/2014

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 Anesthesiology and Pain 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 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 60-year-old female who reported an injury on 04/02/1999. The injured worker developed chronic pain that was managed with multiple medications. The injured worker was evaluated on 05/01/2014. It was noted that the injured worker's medications to include Ambien, Norco, and TGHOT cream allowed the injured worker to work. Physical findings of the cervical spine included restricted range of motion secondary to pain with scapular retraction limited due to rhomboid pain. It was noted that the injured worker had a mildly positive head compression sign, bilateral Tinel's sign and Phalen's sign and decreased sensation over the median distribution. It was noted that the injured worker had previously undergone a urinalysis on 03/25/2014 that was consistent with the injured worker's prescribed medication schedule. The injured worker's diagnoses included left knee meniscectomy/internal derangement, status post arthroscopy, spinal contusion, spinal strain, L4-5 disc protrusion, right knee contusion, wrist contusion, status post right hip surgery, right trochanteric bursitis, anxiety and depression, hypertension, sleep disturbance, and gastrointestinal disorder. A request was made for a refill of medications. A request for authorization for Norco, Ambien, and TGHOT was submitted on 05/01/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #90 refills 3: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The requested Norco 10/325 mg #90 with 3 refills is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends that continued use of opioids be supported by documented functional benefit, a quantitative assessment of pain relief, evidence that the injured worker's is monitored for aberrant behavior, and managed side effects. The clinical documentation submitted for review does indicate that the injured worker is monitored for side effects with urine drug screens and that the injured worker's medications allow her to participate in work activities. However, the clinical documentation fails to provide a quantitative assessment of pain relief to support the efficacy of this medication. Furthermore, the request is for 3 refills. This does not allow for timely reassessment and re-evaluation. The California Medical Treatment Utilization Schedule recommends ongoing documentation to support opioid usage. Additionally, the request as it is submitted does not clearly identify frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Norco 10/325 mg #90 with 3 refills is not medically necessary or appropriate.

Ambien 10mg # 30 refills 3: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: The requested Ambien 10 mg #30 with 3 refills is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not specifically address this medication. Official Disability Guidelines recommend pharmacological intervention for insomnia related to chronic pain for short durations of treatment. The clinical documentation submitted for review indicates that the injured worker has been on this medication since at least 09/2013. This in combination with the requested additional 3 refills would exceed guideline recommendations. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Ambien 10 mg #30 with 3 refills is not medically necessary or appropriate.

TGHot cream 240gm (quantity /refills unspecified): 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 Other Medical Treatment Guideline or Medical Evidence: Effectiveness of topical administration of opioids in palliative care: a systematic review; B LeBon, G Zeppetella, IJ Higginson - Journal of pain and symptoms,2009 - Elsevier.

Decision rationale: The requested decision for TGHot cream 240 gm (quantity of refills unspecified) is not medically necessary or appropriate. The requested medication is a compounded medication that contains tramadol, gabapentin, menthol, camphor, and capsaicin. The California Medical Treatment Utilization Schedule does not recommend the use of capsaicin as a topical analgesic unless the patient has failed to respond to all other first line treatments. The clinical documentation submitted for review does not provide any evidence that the patient has failed to respond to first line treatment such as antidepressants and anticonvulsants. Therefore, the use of this medication in a topical formulation would not be supported. The California Medical Treatment Utilization Schedule does not support the use of gabapentin, as there is little scientific evidence to support the efficacy and safety of this medication. The California Medical Treatment Utilization Schedule and Official Disability Guidelines do not address the use of tramadol in a topical formulation. Peer reviewed literature does not support the use of opioids in a topical formulation as there is little scientific evidence to support the efficacy and safety of this medication. Furthermore, the request as it is submitted does not clearly identify a quantity of applicable body part. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested TGHot cream 250 gm is not medically necessary or appropriate.