

Case Number:	CM14-0011315		
Date Assigned:	06/11/2014	Date of Injury:	06/03/2010
Decision Date:	07/15/2014	UR Denial Date:	01/17/2014
Priority:	Standard	Application Received:	01/28/2014

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 Physical Medicine and 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 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 55-year-old injured on June 3, 2010, due to undisclosed mechanism of injury. Current diagnoses included chronic right shoulder pain status post biceps tendon injury and surgery and right lateral epicondylitis with surgical intervention. Clinical note dated January 3, 2013 indicated the injured worker presented complaining of right arm pain rated 5/10 decreased with medication. Physical examination revealed presence of lateral epicondyle brace on the right arm, marked tenderness over the scar that appeared to be a neuroma, tenderness over the biceps tendon on the right, shoulder abduction limited to approximately 30 degrees with little forward flexion, shoulder forward flexion limited to approximately 5-10 degrees, and painful range of motion. Medications included Elavil 25mg every evening, Ultram 15mg twice daily, Lidoderm patch once daily, and Celebrex 200mg once daily. Plan of care included continuation of medication management. The initial request for Celebrex 200mg #30 three refills, Lidoderm patches 5% #30, and compound flurbiprofen 10%, ketamine 10%, gabapentin 10%, lidocaine 2%, and prilocaine 2% #240 were initially non-certified on January 17, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

CELEBREX 200MG, THIRTY COUNT WITH THREE REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cox- Selective Agents.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, NSAIDS, SPECIFIC DRUG LIST & ADVERSE EFFECTS Page(s): 70.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended as a second-line treatment after acetaminophen for acute exacerbations of chronic pain. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute lower back pain. Package inserts for NSAIDs recommend periodic lab monitoring of a CBC (complete blood count) and chemistry profile (including liver and renal function tests). There is no documentation that these monitoring recommendations have been performed and the injured worker is being monitored on a routine basis. Additionally, it is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time. The request for celebrex 200mg, thirty count with three refills, is not medically necessary or appropriate.

LIDODERM PATCHES 5%, THIRTY COUNT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Page(s): 9 and 112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, LIDODERM (LIDOCAINE PATCH) Page(s): 56.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Lidoderm is recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. There should be evidence of a trial of first-line neuropathy medications (tri-cyclic or SNRI [serotonin-norepinephrine reuptake inhibitor] antidepressants or an AED [anti-epileptic drug] such as gabapentin or Lyrica). Lidoderm is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. The request for lidoderm patches 5%, thirty count, is not medically necessary or appropriate.

COMPOUND FIBUPROFEN 10%? KETAMINE 10%/ GABAPENTIN 10%/ LIDOCAINE 2%? PRILOCAINE 2% #240: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, TOPICAL ANALGESICS Page(s): 111.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Further, California Medical Treatment Utilization Schedule, Food and Drug Administration, and Official Disability Guidelines require

that all components of a compounded topical medication be approved for transdermal use. This compound contains multiple components which have not been approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. The request for compound Fibuprofen 10%/Ketamine 10%/Gabapentin 10%/ Lidocaine 2%/Prilocaine 2%, 240 count, is not medically necessary or appropriate.