

<b>Case Number:</b>	CM14-0012172		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	08/12/2006
<b>Decision Date:</b>	08/05/2014	<b>UR Denial Date:</b>	01/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/30/2014

### 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, has a subspecialty in Pain Management 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:

This is a 57-year-old female with a 8/12/06 date of injury. The mechanism of injury was not noted. In a 2/12/14 progress note, the patient continued to have ongoing and debilitating pain in her neck with cervicogenic headaches that radiated down both upper extremities. She rated her pain as an 8 intensity from 0-10. She continued to complain of pain in her lower back. The patient has been stable on her medication regimen, and she wants to cut back on her Oxycontin. Unfortunately, she has been requiring higher doses of her Norco. Objective findings: tenderness along the posterior musculature regions, upper trapezius, and medial scapular regions bilaterally, limited left shoulder abduction to about 90 to 100 degrees, tenderness to palpation along the posterior lumbar musculature bilaterally with a significantly decreased range of motion. Diagnostic impression: Cervical herniated nucleus pulposus, left upper extremity radiculopathy, left lower extremity radiculopathy, right and left total knee arthroplasty, bilateral carpal tunnel syndrome, and medication induced gastritis. Treatment to date: medication management, activity modification, physical therapy, and surgery. A UR decision dated 1/30/14 modified the request for Norco 10/325 mg from 180 tablets to 120 tablets. The treating provider reported the patient has decreased her Norco use from 4 tablets per day to 2 tablets per day. The current request for 180 is a two month supply. In a generic statement, it is reported that the patient has undergone a urine drug screen, however, the date and results of the most recent screen were not provided. The request for Cymbalta 60 mg was modified from 130 tablets to 30 tablets. There is no rationale as to why 130 tablets were ordered. The request for Ambien was denied. The use of Ambien is supported for short-term use of 2-6 weeks duration. The documentation does not describe failure of behavioral interventions including following sleep hygiene techniques. The request for Dendracin cream was denied. Benzocaine is comparable to lidocaine which is recommended for localized peripheral pain after there has been evidence of a trial of first-line

therapy. This has not been documented. Furthermore, guidelines only support it as a dermal patch.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Norco 10/325mg #180:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In a 2/14/14 progress note, the physician noted that the pain medications enable her to be functional throughout the day. She was able to perform simple chores around the house including cooking and cleaning with less pain. In addition, a urine drug screen dated 11/14/13 was consistent for the use of Hydrocodone. However, in progress notes dated 11/11/13, 1/13/14 and 1/24/14 document the patient says she has cut down her Norco to 2 tablets. This request is for 180 tablets which equals a 90 day supply of the medication. Therefore, the request for Norco 10/325 mg #180, as submitted, is not medically necessary.

**Cymbalta 60 mg #130:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 15-16.

**Decision rationale:** CA MTUS states that Duloxetine (Cymbalta) is FDA-approved for anxiety, depression, diabetic neuropathy, and fibromyalgia; is used off-label for neuropathic pain and radiculopathy, and is recommended as a first-line option for diabetic neuropathy. Guidelines do support the use of antidepressants for the treatment of chronic pain, particularly neuropathic type pain. The documentation identifies the patient to have ongoing symptoms of neuropathic pain and reports relief with her medication regimen. However, the patient is noted to be taking this medication daily. There is no rationale from the treating provider as to why 130 tablets, more than a 4 month supply was ordered. Therefore the request for Cymbalta 60 mg #30 is not medically necessary.

**Ambien CR 12.5 mg #30:** 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 Chapter, Zolpidem (Ambien).

**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 (Ambien) and FDA (Ambien).

**Decision rationale:** CA MTUS does not address this issue. ODG and the FDA state that Ambien is approved for the short-term (usually two to six weeks) treatment of insomnia. Additionally, pain specialists rarely, if ever, recommend Ambien for long-term use. The patient has been on Ambien since at least 9/11/13, if not earlier. Guidelines do not support the long-term use of sedative hypnotics for insomnia. In addition, there is no documentation that the provider has discussed proper sleep hygiene with the patient. Furthermore, there is no documentation in the notes reviewed that the patient is suffering from insomnia or a sleep disturbance. Therefore, the request for Ambien CR 12.5 mg #30 is not medically necessary.

**Dendracin Topical Analgesic Cream #1:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113. Decision based on Non-MTUS Citation FDA (Topical Medication Safety Warning).

**Decision rationale:** A search of on-line resources revealed that Dendracin (Methyl Salicylate/Benzocaine/Menthol) is a topical analgesic used for the temporary relief of minor aches and pains caused by arthritis, simple backache, and strains. However, CA MTUS Chronic Pain Medical Treatment Guidelines state that there is little to no research to support the use of local anesthetics in topical compound formulations. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Guidelines do not support the use of benzocaine in a topical compound formulation. Furthermore, FDA safety warning identifies that cases of serious burns on the skin have occurred with use of products containing menthol and methyl salicylate. A specific rationale identifying why Dendracin cream would be required in this patient despite lack of guideline support was not provided. Therefore, the request for Dendracin Topical Analgesic Cream #1 is not medically necessary.