

Case Number:	CM14-0142628		
Date Assigned:	09/10/2014	Date of Injury:	01/29/2010
Decision Date:	11/01/2014	UR Denial Date:	08/22/2014
Priority:	Standard	Application Received:	09/02/2014

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 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 49-year-old female who has submitted a claim for bilateral shoulder impingement with possible SLAP lesion, left ulnar neuritis, left lateral epicondylitis, left wrist inflammation, carpal tunnel syndrome, and sleep disturbance associated with an industrial injury date of 1/29/2010. Progress report from 8/5/2014 was the only note available for review. The patient complained of pain at both shoulders, left elbow, left wrist, and low back. The patient reported numbness and tingling sensation at the left upper extremity. The patient likewise complained of sleep disturbance. Physical examination showed tenderness along the shoulder blade. Ulnar nerve tenderness was also noted. Hyperflexion test was positive and pinwheel function was weak. Two-point discrimination was aberrant along the elbow pad including the ulnar half and the little finger on the left. MRI of the shoulder, undated, showed evidence of impingement, with possible SLAP tear. Treatment to date has included cortisone injections, use of a TENS unit, hot/cold modality, elbow brace, activity restrictions, trigger point injections, and medications such as Flexeril, naproxen, Protonix, Terocin patches, topical cream, and Ativan (since August 2014). Utilization review of 8/22/2014 denied the request for Tramadol ER 150 mg #30 because prolonged use of narcotic medication was not recommended; denied naproxen 550 mg, #60 because long-term use was not recommended; denied Protonix 20 mg, #60 because there was no gastrointestinal risk factor present; denied Terocin patches #13 because compounded medication was not guideline recommended due to limited published study concerning its efficacy and safety; denied Lidopro cream 1 bottle because of limited published study concerning its efficacy and safety; and denied Ativan 1mg #60 because of no evidence of anxiety disorder, sleep disorder, or muscle spasm to support its use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol ER 150 mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 94.

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

Decision rationale: As stated on page 78 of the California MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, the exact initial date of Tramadol prescription is unclear due to insufficient documentation, given that the date of injury is 2010. The medical records do not clearly reflect continued analgesia, continued functional benefit, or a lack of adverse side effects. Urine drug screen is likewise not available for review. MTUS Guidelines require clear and concise documentation for ongoing management. Therefore, the request for Tramadol ER 150 mg, #30 is not medically necessary.

Naproxen 550mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 46.

Decision rationale: As stated on page 46 of the California MTUS Chronic Pain Medical Treatment guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and that there is no evidence of long-term effectiveness for pain or function. In this case, the exact initial date of Naproxen prescription is unclear due to insufficient documentation, given that the date of injury is 2010. However, there is no documentation concerning pain relief and functional improvement derived from its use. Long-term use is likewise not recommended. The medical necessity cannot be established due to lack of information. Therefore, the request for Naproxen 550mg, #60 is not medically necessary.

Protonix 20 mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), TWC Pain, NSAIDs, GI symptoms & cardiovascular risk, Prilosec

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms, and Cardiovascular Risk Page(s): 68.

Decision rationale: As stated on page 68 of the California MTUS Chronic Pain Medical Treatment Guidelines, clinicians should weigh the indications for NSAIDs against both GI and cardiovascular risk factors: age > 65 years, history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, or anticoagulant; or on high-dose/multiple NSAIDs. Patients with intermediate risk factors should be prescribed proton pump inhibitors (PPI). In this case, the exact initial date of PPI prescription is unclear due to insufficient documentation, given that the date of injury is 2010. There is no subjective report of heartburn, epigastric burning sensation or any other gastrointestinal symptoms that may corroborate the necessity of this medication. Furthermore, patient does not meet any of the aforementioned risk factors. The guideline criteria are not met. Therefore, the request for Protonix 20mg, #60 is not medically necessary.

Terocin patches #30: 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 Lidocaine patch Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Section, Topical Salicylate

Decision rationale: Terocin patch contains both Lidocaine and Menthol. Pages 56 to 57 of the California MTUS Chronic Pain Medical Treatment Guidelines state that topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an anti-epilepsy drug such as Gabapentin or Lyrica). Regarding the Menthol component, the California MTUS does not cite specific provisions, but the Official Disability Guidelines Pain Chapter states that the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain Menthol, Methyl Salicylate, or Capsaicin, may in rare instances cause serious burns. In this case, the exact initial date of Terocin patch prescription is unclear due to lack of documentation, given that the date of injury is 2010. There is no documentation that the patient had initially tried first-line therapy. The medical necessity cannot be established due to insufficient information. Therefore, the request for Terocin patches, #30 is not medically necessary.

Lidopro cream 1 bottle: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Capsaicin, Salicylates, Topical Analgesics Page(s): 28 - 29; 105; 111-113.

Decision rationale: LidoPro lotion contains Capsaicin 0.0325%, Lidocaine 4.5%, Menthol 10%, and Methyl salicylate 27.5%. The California MTUS does not cite specific provisions regarding menthol, but the Official Disability Guidelines Pain Chapter states that the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain Menthol, Methyl Salicylate, or Capsaicin, may in rare instances cause serious burns. Topical Salicylate is significantly better than placebo in chronic pain as stated on page 105 of MTUS Chronic Pain Medical Treatment guidelines. Pages 111-112 further states that there is little to no research to support the use of Lidocaine for compounded products, and Lidocaine is not recommended for topical use. Moreover, there is little to no research to support the use of Capsaicin 0.0325% in topical compound formulations. In this case, patient has been prescribed LidoPro lotion as adjuvant therapy to oral medications. However, guidelines state that any compounded product that contains at least one drug that is not recommended is not recommended. Lidocaine is not recommended for topical use, and Capsaicin in 0.0325% formulation is likewise not recommended. Therefore, the request for LidoPro cream 1 bottle is not medically necessary.

Ativan 1mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: As stated on page 24 of the California MTUS Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. In this case, the exact initial date of Ativan prescription is unclear due to lack of documentation, given that the date of injury is 2010. There is complaint of sleep disturbance; however, there is no discussion concerning sleep hygiene. The medical necessity cannot be established due to insufficient information. Therefore, the request for Ativan 1mg, #60 is not medically necessary.