MAXIMUS Federal Services

Case Number:	CM14-0181057		
Date Assigned:	11/07/2014	Date of Injury:	09/12/2003
Decision Date:	12/11/2014	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/31/2014

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, 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 58 year old female with an injury date of 09/12/03. Per the 07/17/14 progress report, the patient presents with constant right shoulder pain rated 9/10, constant right wrist pain with numbness and tingling rated 10/10 without medication. Recent reports do not state if the patient is working; however, she was not working as of 01/13/14. Examination of the right shoulder reveals impingement positive on the right with tenderness of trapezius and parascapular muscles with spasms as well as tenderness of the carpals for the right wrist. Right upper extremity sensation is "increased" at C6-C8. The patient's diagnoses include right wrist/hand carpal Tunnel Syndrome, right, and status post right shoulder surgery (date unknown). Medications are listed as Soma, Norco, Terocin Patch, Menthoderm Gel, Xolindo, Terocin cream, Flurbinap cream, Gabacyclotram cream, Genicin, and Somnicin. The utilization review being challenged is dated 09/25/14. Reports were provided from 09/04/13 to 07/24/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29.

Decision rationale: The patient presents with constant right shoulder and constant right wrist pain rated 9-10/10 without medication. The treating physician is requesting SOMA 350 mg #90 (Carisoprodol). The report show the patient has been taking this medication since at least 01/18/14. MTUS Guidelines, Soma on page 29 states, "Not recommended. This medication is not indicated for long term use." MTUS Guidelines, Muscle relaxants for pain on pages 63-66 states that this formulation is recommended for no longer than 2-3 weeks. The treating physician does not discuss the use of this medication in the reports provided. In this case, this medication has been used by the patient longer than the 2-3 weeks recommended by MTUS. Furthermore, the Request for Authorization dated 09/18/14 requests for a quantity of 90 which does not indicate short-term use. Therefore, this request is not medically necessary.

Ambien 10mg #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 (ODG), Pain Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness and Stress Chapter, Zolpidem (Ambien)

Decision rationale: The patient presents with constant right shoulder and constant right wrist pain rated 9-10/10 without medication. The treating physician is requesting AMBIEN 10 mg #30. The reports show the patient has been taking this medication since at least 01/18/14. Official Disability Guidelines (ODG), Mental Illness and Stress Chapter, Zolpidem (Ambien), states, "Not recommended for long-term use, but recommended for short-term use." ODG, Pain Chapter further states usually two to six weeks for treatment of insomnia. It is further stated that this medication is recommended for 7-10 days treatment of insomnia. The 03/31/14 report states that the patient was recognized with muti-factorial sleep disturbance after evaluation on 01/13/14, and this medication is indicated for insomnia. However, the treating physician does not state the intended use of the medication and whether or not it helps the patient in the reports provided. Furthermore, the reports show the patient has been taking this medication longer than the up to 6 weeks recommended by ODG. Therefore, this request is not medically necessary.

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 Criteria for use of opioids Page(s): 78, 89-89.

Decision rationale: The patient presents with constant right shoulder and constant right wrist pain rated 9-10/10 without medication. The reports show the patient has been taking this medication since at least 01/18/14. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS Guidelines page 78 also requires documentation of the 4As (analgesia, activities of daily livings (ADLs), adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. The treating physician does not discuss this medication in the reports provided. Pain is routinely assessed with the use of pain scales, and is rated without medications as 10/10 and with medications as 4-5/10 on 01/18/14 and as 7-9/10 without medications and as 4-5/10 with on 07/24/14. The patient completed an Activities of Daily Living Questionnaire on 01/13/14 that states the patient has difficulty: brushing teeth, bathing, dressing, eating, seeing, hearing, thinking, touching, and tasting, smelling and riding. The patient has no difficulty: combing hair, climbing several flights, walking more than 1 mile, running, lifting/carrying, moving a table, pushing a vacuum cleaner, grasping, lifting or driving. However, no recent specific ADLs are mentioned to show a significant change with use of this medication. The questionnaire only addresses ADL's level but not how opiates are improving function. Opiate management issues are partially discussed. The treating physician repeatedly states that oral medications show no side effects and that risk, benefits and alternatives of medications were discussed with the patient. A Urine Toxicology Report is provided from 09/17/14 which reports "positive" and "consistent" for Hydrocodone and Norhydrocodone and a urine drug screening (UDS) from 06/16/14 reports "negative" and "not consistent for Hydrocodone, Zolpidem and Carisoprodol. The treating physician does not discuss these reports or explain the discrepancy. The following treatment reports state UDS was administered that day: 07/17/14, 07/24/14, 02/19/14 and 01/18/14 with results to follow. There is no follow up discussion of these results, aberrant behavior or CURES. Outcome measures are not provided. Therefore, this request is not medically necessary.

Terocin 120ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine, Topical Lidocaine Page(s): 112.

Decision rationale: The patient presents with constant right shoulder and constant right wrist pain rated 9-10/10 without medication. The reports show the patient has been using this medication since at least 01/18/14. MTUS guidelines page 112 state regarding Lidocaine, "Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain." MTUS further states, "any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." The treating physician states that the medication is a Capsaicin/Methyl

Salicylate/Menthol/Lidocaine compound topical and that topical medications have no side effects, decrease pain, increase sleep and increase chores. In this case, MTUS only recommends Lidocaine in patch form. Therefore, this request is not medically necessary.

Flurbi NAP cream - LA 180gms: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine, Topical Lidocaine Page(s): 112.

Decision rationale: The patient presents with constant right shoulder and constant right wrist pain rated 9-10/10 without medication. The reports show the patient has been using this medication since at least 01/18/14. MTUS guidelines page 112 state regarding Lidocaine, "Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain." MTUS further states, "any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." The treating physician states this medication is Flurbiprofen/Lidocaine/Amitriptyline compound cream for the treatment of pain and inflammation. The reports further state that topical medications have no side effects, decrease pain, increase sleep and increase chores. In this case, however, MTUS only recommends Lidocaine in patch form. Therefore, this request is not medically necessary.

Gabacyclotram 180mgs: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Creams, Page(s): 111.

Decision rationale: The patient presents with constant right shoulder and constant right wrist pain rated 9-10/10 without medication. The reports show the patient has been using this medication since at least 01/18/14. The MTUS has the following regarding topical creams (page 111, chronic pain section): "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." The treating physician states that this medication is a gabapentin, Cyclobenzaprine, Tramadol compound topical for treatment of pain and inflammation. The reports further state that topical medications have no side effects, decrease pain, increase sleep and increase chores. In this case, however, Cyclobenzaprine and Tramadol are not supported for topical formulation and MTUS specifically states that gabapentin is not recommended under the topical cream section. Therefore, this request is not medically necessary.

Genicin #90 capsules: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate) Page(s): 50.

Decision rationale: The patient presents with constant right shoulder and constant right wrist pain rated 9-10/10 without medication. MTUS guidelines page 50 states that this medication is recommended as an option in patients with moderate arthritis pain, especially for knee osteoarthritis. The treating physician states this medication (Glucosamine sodium) is for the treatment of arthritic pain. In this case, there is no discussion or diagnosis of osteoarthritis in this patient, particularly of the knee. Therefore, this request is not medically necessary.

Somnicin #30 capsule: 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), Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain Page(s): 60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Melatonin, Insomnia Treatment Chapter

Decision rationale: The patient presents with constant right shoulder and constant right wrist pain rated 9-10/10 without medication. The reports show the patient has been taking this medication since at least 01/18/14. Official Disability Guidelines (ODG), Melatonin, states it is, "Recommended. See Insomnia treatment. There are also experimental and clinical data supporting an analgesic role of melatonin. In published studies melatonin shows potent analgesic effects in a dose-dependent manner, and melatonin has been shown to have analgesic benefits in patients with chronic pain. Also, the repeated administration of melatonin improves sleep and thereby may reduce anxiety, which leads to lower levels of pain." The treating physician states this medication is Melatonin/Tryptophan/Pyridoxine for treatment of insomnia, anxiety and muscle relaxation. The 03/31/14 report states, the patient was recognized with muti-factorial sleep disturbance after evaluation on 01/13/14 and this medication is indicated for insomnia. The treating physician does state that oral medications for the patient are without side effects; however, it is not stated whether or not Somnicin helps the patient. MTUS Guidelines, Medications for Chronic Pain page 60 states, a record of pain and function must be recorded when medications are used for chronic pain. Therefore, this request is not medically necessary.

Terocin pain patch #20: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Lidocaine Page(s): 112.

Decision rationale: The patient presents with constant right shoulder and constant right wrist pain rated 9-10/10 without medication. The reports show the patient has been taking this medication since at least 01/18/14. The MTUS guidelines page 112 regarding topical lidocaine states, neuropathic pain: "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 AED such as gabapentin or Lyrica)." When reading Official Disability Guidelines (ODG) it is recommended for neuropathic pain that is localized and peripheral. The treating physician states this medication is for the treatment of minor aches and muscle pains. The reports further state that topical medications have no side effects, decrease pain, increase sleep and increase chores. The patient presents with constant "right wrist" pain with "numbness and tingling" for which this medication may be indicated. However, the treating physician is using it for minor aches and muscle pains, and not neuropathic pain. Therefore, this request is not medically necessary. .

Menthoderm gel 120ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics (NSAIDs) Page(s): 111.

Decision rationale: The patient presents with constant right shoulder and constant right wrist pain rated 9-10/10 without medication. The reports show the patient has been using this medication since at least 01/18/14. MTUS guidelines on page 111 states that topical analgesics (NSAIDs) are indicated for peripheral joint arthritis/tendinitis. Menthoderm is a compound analgesic containing Methyl Salicylate and Menthol. The treating physician states that topical medications have no side effects, decrease pain, increase sleep and increase chores and this medication is for the temporary relief of minor aches and pains. In this case, however, the treating physician appears to be using multiple topical products and they are not discussed individually in terms of where it is used with what effectiveness. There is no indication that Menthoderm is instrumental in controlling the patients' wrist and hand symptoms to improve pain and function. Therefore, this request is not medically necessary.

Xolindo 2% cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine, Topical Lidocaine Page(s): 112. Decision based on Non-MTUS Citation National Institutes of Health, National Library of Medicine.

http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f2b463d7-3fcf-4b2c-8ba2-8e51e3290de2

Decision rationale: The patient presents with constant right shoulder and constant right wrist pain rated 9-10/10 without medication. MTUS guidelines page 112 state regarding Lidocaine, "Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain." MTUS further states, "any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." National Institutes of Health, National Library of medicine states the active ingredient of this medication is Lidocaine HCL 2%. The treating physician states Xolindo is for the temporary relief of pain and itching and minor skin irritations due to minor cuts and scrapes, sunburn and minor burns. In this case, lidocaine is only indicated in patch formulation. Therefore, this request is not medically necessary.

Urine drug screen, retrospective 7/17/14: 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), Pain Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic) Chapter, Urine Drug Testing (UDT)

Decision rationale: The patient presents with constant right shoulder and constant right wrist pain rated 9-10/10 without medication. The treating physician is requesting authorization for a retrospective urine drug screen dated 07/17/2014. MTUS guidelines do not specify the frequency of urine drug screens (UDS) for risks of opiate users. Official Disability Guidelines (ODG), however, recommends once yearly urine screen following initial screening with the first 6 months for management of chronic opiate use in low risk patient. For moderate and high risk, more frequent UDS's are recommended. The reports provided include urine toxicology tests from 09/17/14 and 06/16/14. The 09/17/14 test reports tested "positive" and "consistent" for Norhydrocodone and Hydrocodone. The 06/16/14 report states "negative" and "not consistent for Hydrocodone, Zolpidem and Carisoprodol. The following reports also state that a UDS was administered on that date: 07/17/14, 02/19/14 and 01/18/14; however, copies of these reports are not provided or discussed. The patient is documented to be a long term-user of opioids (Norco) since at least 01/18/14. In this case, 3-4 UDS's per year may be appropriate for high risk opiate users, but too frequent for routine monitoring. The treating physician does not provide risk assessment, and the reports indicate 5 reports in less than one year. Therefore, this request is not medically necessary.