

Case Number:	CM14-0020170		
Date Assigned:	02/21/2014	Date of Injury:	09/10/2010
Decision Date:	08/04/2014	UR Denial Date:	01/31/2014
Priority:	Standard	Application Received:	02/19/2014

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 Pain Management and is licensed to practice in Texas and Oklahoma. 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 30-year-old female with a reported date of injury of 09/10/2010. The mechanism of injury was not submitted with the medical records. Her diagnoses were noted to include cervical hyperextension/hyper-flexion, mild cervical discopathy, lumbar hyperextension/hyper-flexion, lumbar discopathy, bilateral shoulder impingement, bilateral upper extremity overuse tendinitis, anxiety, depression, gastrointestinal disturbance, and sleep disturbance. The injured worker has previously undergone nerve conduction studies, acupuncture, and electrical shock. The progress note dated 01/03/2014 reported the injured worker complained of increased bilateral wrist pain with constant numbness and tingling, rated at 6/10. The injured worker also complained of neck pain with radiation to the bilateral trapezius muscles, rated at 5/10 and constant. The progress note also reported the injured worker complained of back pain. The range of motion testing to the cervical spine was performed on 01/03/2014 and demonstrated flexion 30 degrees, extension 20 degrees, lateral rotation right/left 60 degrees, and lateral tilt right/left 40 degrees. The motor strength testing was 5/5. The progress note dated 01/03/2014 reported a positive Tinel's sign as well as a positive Phalen's sign and decreased sensation to pinprick in the median distribution. The progress note reported wrist power was inhibited by forearm pain; however, no sign of wrist instability was noted. The wrist range of motion testing was performed and was reported to be normal in all ranges bilaterally. The treatment plan included Tramadol 50mg #60 with 3 refills for pain, Ambien 10mg #30 with 3 refills for sleep, Tizanidine 4mg #60 with 3 refills for muscle spasm, Fluriflex cream 180gm and TGIce cream 180gm for immediate pain relief, urinalysis drug screening to monitor medication compliance, 8 physical therapy sessions for the cervical spine, and 8 physical therapy

sessions for the bilateral wrists due to increased symptomology. However, the request for authorization form was not submitted within the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRAMADOL 50MG, #60 WITH 3 REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, Ongoing Management Page(s): 78.

Decision rationale: The injured worker has been taking tramadol since 06/2013. According to the Chronic Pain Medical Treatment Guidelines, the ongoing use of opioid medications may be supported with detailed documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines also state that the 4A's for ongoing monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. There is a lack of adequate documentation regarding the numeric pain rating before and after the opioid; therefore, the effectiveness cannot be established. In addition, documentation failed to address functional improvement and adverse effects. A urine drug screen taken 07/26/2013 reported Tramadol positive as prescribed; however, Cyclobenzaprine and Zolpidem were not detected and the documentation failed to show evidence that a discussion was held regarding these inconsistent results. Therefore, in the absence of documented evidence of pain relief, increased function, possible adverse effects, and documentation regarding the injured worker's inconsistent urine drug screen result, continue use of Tramadol is not supported. The request as submitted failed to provide the frequency of the medication. Therefore, the request for Tramadol 50mg is not medically necessary.

AMBIEN 10MG, #30 WITH 3 REFILLS: 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 (Chronic).

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

Decision rationale: The injured worker has been taking Ambien since at least 06/2013. The ODG recommends Ambien for the short term (usually 2 to 6 weeks) treatment of insomnia. The guidelines state that Ambien can be habit forming, and may impair function and memory more than opioid pain relievers as well as Ambien may increase pain and depression over the long term. The injured worker has been taking Ambien for over 6 months which would exceed guideline recommendation for this medication. There is a lack of documentation regarding the

efficacy of Ambien for the injured worker's sleep disturbance. The urine drug screen documented Zolpidem as not detected which is inconsistent with prescribed therapy. The request as submitted failed to provide the frequency of the medication. For these reasons, the request for Ambien 10mg is not medically necessary.

TIZANIDINE 4MG, #60 WITH 3 REFILLS: 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 (Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants, Antispasticity/Antispasmodic Drugs, Tizanidine Page(s): 63,66.

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short-term treatment of acute exacerbations in injured workers with chronic low back pain. The guidelines state efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. The Chronic Pain Medical Treatment Guidelines recommend Tizanidine as a first line use for myofascial pain and unlabeled use for low back pain. There is a lack of documentation regarding the efficacy of this medication for her cervical and thoracic regional muscle spasms and documentation of significant functional improvement gained by utilizing Tizanidine. The injured worker has been using this medication for over six months and the guidelines recommend a short-term use for acute exacerbation. The request as submitted failed to provide the frequency of the medication. Therefore, the request for Tizanidine 4mg is not medically necessary.

FLURIFLEX (FLURBIPROFEN/CYCLOBENZAPRINE 15/10%) CREAM 180GM:
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, Other Muscle Relaxants Page(s): 111, 113.

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommend topical analgesics for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. The guidelines state that any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The guidelines state that topical NSAIDs are recommended for both osteoarthritis and tendinitis, in particular, that of the knee and/or elbow or other joints that are amenable to topical treatment are recommended for short term use of topical NSAIDs. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. The guidelines also state that there is no evidence for the use of any muscle relaxant as a topical medication such as cyclobenzaprine. The guidelines recommend topical NSAIDs for

osteoarthritis and tendinitis particularly in the knee and elbow or other joints that are amendable for short term use (4-12 weeks). The injured worker does not have a diagnosis of upper extremity tendinitis. The injured worker has been utilizing this medication for over 6 months and there is a lack of documentation regarding the efficacy of the medication as well as an indication of significant functional improvement with the use of this medication. Additionally, the guidelines do not recommend muscle relaxants for topical application. As this medication contains a drug that is not recommended, the medication would not be indicated. For these reasons, the request for Fluriflex (flurbiprofen/cyclobenzaprine 15/10%) cream 180gm is not medically necessary.

**TGIce (TRAMADOL/GABAPENTIN/MENTHOL/CAMPHOR 8/10/2/2%) CREAM
180GM: Upheld**

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines primarily recommend topical analgesics for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. The guidelines also state any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines state the efficacy in clinical trials for this treatment modality have been inconsistent and most studies are small and of short duration. The guidelines do not recommend Gabapentin for use in a topical analgesic being that there is no peer-reviewed literature to support the use. The guidelines do not recommend Gabapentin for use in a topical analgesic. The guidelines also state if the compounded product contains one drug or drug class that is not recommended, is not recommended. As this medication contains a drug that is not recommended, the medication would not be indicated. Therefore, the request for TGIce (tramadol/gabapentin/menthol/camphor 8/10/2/2%) cream 180gm is not medically necessary.

URINALYSIS DRUG SCREENING: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing; Opioids, pain treatment agreement; Opioids, steps to avoid misuse/addiction Page(s): 43, 89, 94.

Decision rationale: The injured worker has undergone two drug screenings in the year of 2013. The Chronic Pain Medical Treatment Guidelines recommend drug testing as an option to assess for the use of presence of illegal drugs. The guidelines recommend pain treatment agreement and urine drug screens may be required. The guidelines recommend random urine drug screens for those at high risk of abuse. There is a lack of documentation regarding the use of a pain treatment agreement. The last urine drug screen reported was performed on 07/26/2013 which

was positive for Tramadol which is consistent with prescription therapy; however, Cyclobenzaprine and Zolpidem were not detected which is inconsistent with the injured workers prescribed medication regimen. There is a lack of documentation regarding a detailed discussion of the inconsistent drug screen. Within the 01/13/2014 progress note, the provider indicated a urine drug screen was performed; however, no results were provided which would be needed in order to determine whether a repeat urine drug screen would be indicated. Therefore, the request for a urinalysis drug screening is not medically necessary.

EIGHT PHYSICAL THERAPY SESSIONS FOR THE CERVICAL SPINE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The injured worker has undergone nerve conduction tests, acupuncture, and electrical shock and has reported functional deficits to the cervical spine. The Chronic Pain Medical Treatment Guidelines recommend physical therapy as an active therapy requiring an internal effort by the individual to complete a specific task or exercise. The guidelines also recommend the injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The guidelines recommend 8-10 physical therapy visits to promote functional gains. The injured worker was shown to have decreased range of motion to the cervical spine; however, the documentation fails to indicate whether the injured worker has participated in previous physical therapy to the cervical spine since her injury in 2010, and whether she had functional improvement with that treatment. Therefore, despite the current functional deficits, in the absence of details regarding previous treatments, physical therapy would not be indicated at this time. Therefore, the request for physical therapy of the cervical spine is not medically necessary.

EIGHT PHYSICAL THERAPY SESSIONS FOR THE BILATERAL WRIST: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The injured worker has undergone nerve conduction testing, acupuncture, electrical shock, and has full range of motion to the bilateral wrists. The Chronic Pain Medical Treatment Guidelines state that active therapy requires an internal effort by the individual to complete a specific exercise or task. The guidelines also state that injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The injured worker was shown to have full range of motion to the wrists. There was a lack of documentation of significant functional deficits. The documentation fails to indicate if she has had previous physical therapy to the bilateral wrists

since her injury in 2010 and if she had functional improvements with that treatment. In absence of details regarding previous treatments, physical therapy would not be indicated at this time. Therefore, the request for eight physical therapy sessions for the bilateral wrist is not medically necessary.