

Case Number:	CM14-0028873		
Date Assigned:	06/16/2014	Date of Injury:	02/15/2012
Decision Date:	09/10/2014	UR Denial Date:	02/14/2014
Priority:	Standard	Application Received:	03/06/2014

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 & Rehabilitation, 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:

The patient is a 48 year old with an injury date on 2/15/12. Patient complains of bilateral shoulder pain, bilateral elbow pain with radiation to hands, and bilateral left wrist pain with numbness/tingling per 2/3/14 report. Based on the 2/3/14 progress report provided by [REDACTED]. [REDACTED] the exam showed the diagnoses of: 1. Left Shoulder Impingement Syndrome; 2. Left Shoulder Myoligamentous injury; 3. Left Shoulder s/s; 4. Right Shoulder Impingement Syndrome; 5. Right Shoulder Myoligamentous Injury; 6. Right Shoulder s/s; 7. Left Elbow s/s; 8. Left Lateral Epicondylitis; 9. Right Elbow s/s; 10. Right Lateral Epicondylitis; 11. Left Carpal s/s; 12. Left Carpal Tunnel Syndrome; 13. Left Wrist s/s; 14. Right Carpal s/s; 15. Right Carpal Tunnel Syndrome; 16. Right Wrist s/s. [REDACTED] is requesting retro Flurbiprofen 20% Tramadol 20% in Mediderm base 30 grams and retro Gabapentin 10% Dextromethorphan 10% Amitriptyline 10% in Mediderm base 30gm. The utilization review determination being challenged is dated 2/14/14. [REDACTED] is the requesting provider, and he provided treatment reports from 8/26/13 to 5/30/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETRO FLURBIPROFEN 20 PERCENT/TRAMADOL 20 PERCENT IN MEDIDERM BASE 30 GRAMS: Upheld

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

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

Decision rationale: This patient presents with bilateral upper extremity pain. The provider has asked for retro Flurbiprofen 20% Tramadol 20% in Mediderm base 30 grams on 2/3/14. Regarding topical analgesics, MTUS states "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." MTUS for topical NSAIDs recommends for relief of osteoarthritis in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). The patient does not present with symptoms of osteoarthritis and thus, a topical NSAID such as Flurbiprofen would not be indicated. As Flurbiprofen is not indicated, the entire requested compounded topical cream is also not indicated. Therefore, the request is not medically necessary.

RETRO GABAPENTIN 10 PERCENT/DEXTROMETHORPHAN 10 PERCENT/AMITRIPTYLINE 10 PERCENT IN MEDIDERM BASE 30GM: Upheld

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

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

Decision rationale: This patient presents with bilateral upper extremity pain. The provider has asked for retro Gabapentin 10% Dextromethorphan 10% Amitriptyline 10% in Mediderm base 30gm on 2/3/14. Regarding topical analgesics, MTUS state they are largely experimental in use with few randomized controlled trials to determine efficacy or safety, and recommends for neuropathic pain when trials of antidepressants and anticonvulsants have failed. MTUS states "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." MTUS states there is no evidence for use of any anti-convulsant for topical use. As Gabapentin is not indicated per MTUS guidelines, the entire compounded product would also not be indicated. Therefore, the request is not medically necessary.

RETRO TRAMADOL/L-CARNITINE 40/125 MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain Page(s): 60, 61.

Decision rationale: Based on the 02/03/2014 report, the patient presents with left shoulder pain, right shoulder pain, left elbow pain, right elbow pain, left wrist pain, and right wrist pain. The

request is for Retro Tramadol/ L-Carnitine 40/125 mg #90. None of the reports indicate the impact Tramadol had on the patient. For chronic opiate use, MTUS Guidelines, pages 88 and 89, require a function documentation using a numerical scale or validated instrument at least once every 6 months. Documentation of the 4 A's (analgesia, ADLs, adverse side effects, adverse behavior) is required. It also recommends documentation of chronic pain, average pain, least pain, time it takes for medication to work, and duration of pain relief with medication. None of the reports indicate how Tramadol has helped the patient in terms of decreasing pain or functional improvement. In addition, the provider does not use any numerical scales to assess the patient's pain and function as required by MTUS Guidelines. It should also be noted that topical formulation of tramadol is not discussed or supported by MTUS guidelines. Recommendation is for denial.

RETRO ZOLPIDEM 10 MG #30: Upheld

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

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

Decision rationale: Based on the 02/03/2014 report, the patient presents with left shoulder pain, right shoulder pain, left elbow pain, right elbow pain, left wrist pain, and right wrist pain. The request is for Retro Zolpidem 10 mg #30. The patient began taking Zolpidem on 09/20/13. The MTUS and ACOEM Guidelines do not address Ambien; however, ODG Guidelines states that Zolpidem (Ambien) is indicated for short-term treatment of insomnia with difficulty of sleep onset 7 to 10 days. ODG Guidelines does not recommend long-term use of this medication. Therefore, the request is not medically necessary.