

<b>Case Number:</b>	CM14-0034955		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	02/03/2010
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	03/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/20/2014

### 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 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:

This patient is a 54-year-old female with date of injury of 02/03/2010. Per treating physician's report 10/31/2013, the patient presents with neck pain which is worse, right shoulder pain that is worse, stabbing pain in bilateral shoulders with aching pain in her left shoulder, stabbing pain in bilateral hands, achiness on left hand, stabbing aching pain on upper and lower back and lower extremities. The patient alternates Ultram with Norco and takes Ambien for sleep and diclofenac for inflammation. Urine specimen was obtained to monitor medication use and the patient was given 2 intramuscular injection, 1 consisting of Toradol and second one vitamin B12, which were delivered for symptomatic relief without untoward effect. Right subacromial space injection was provided including 2 mL Celestone and 6 mL of lidocaine. Listed diagnoses are: 1. C5-C6 disk herniation on the right side with radiculopathy. 2. L3-L4 disk herniation. 3. Depression. 4. Hypertension. 5. De Quervain's tenosynovitis. 6. Ganglion cyst. Under treatment plan, the treater explained that the patient was given shoulder injection due to worsening pain. Prescriptions were provided for Norco, which has been effective allowing the patient to perform some activities of daily living, provide relief with the patient's moderate to severe pain and if the medications are not authorized to allow for weaning period. Other medications prescribed were Ambien 10 mg and diclofenac, Ultram 50 mg. Urinalysis was performed. An 11/06/2013 report is the treater's urine drug screen analysis and the patient was consistent with medications being prescribed. There is a progress report dated 09/30/2013 with patient still having persistent severe neck pain with radiation into the right upper extremities and severe low back pain. The patient has returned to work, working modified duties. Diagnoses are the same and the treatment plan is for consideration of epidural steroid injection waiting for

authorization and the same medications were recommended including Norco, diclofenac, omeprazole, tramadol ER, and zolpidem.

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

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

#### **Retrospective injection of Toradol (DOS: 01/17/14): 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, Ketorolac (Toradol).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Page(s): 72. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG guidelines, Pain chapter on Toradol :(<http://www.odg-twc.com/odgtwc/pain.htm#Ketorolac>).

**Decision rationale:** This patient presents with chronic neck, low back, bilateral shoulder, upper extremity, lower extremity pains. The treating physician has provided a Toradol intramuscular injection on 10/31/2013. Regarding Toradol, MTUS Guidelines page 70 states, "This medication is not indicative for minor or chronic painful condition". ODG Guidelines, however, support Toradol injection for shoulder subacromial injection in place of subacromial corticosteroid injection. However, on this case, the treating physician has provided intramuscular injection of the Toradol for the patient's pain and on the same day, providing a subacromial corticosteroid injection. Toradol injections are medications are not indicated for minor or chronic painful condition. There is also a study published on Academic Emergency Medicine volume 5 page 118 through 122 that compared intramuscular Toradol versus oral ibuprofen in emergency department setting that did not show significant difference. Recommendation is for denial.

#### **Retrospective injection of Vitamin B-12 complex (DOS 1/17/14): 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, Vitamin B.

**MAXIMUS guideline:** TThe Expert Reviewer based his/her decision on the Non-MTUS ODG-TWC guidelines online, Pain chapter on: Vitamin B (<http://www.odg-twc.com/odgtwc/pain.htm#ProcedureSummary>)

**Decision rationale:** The treating physician has provided intramuscular injection and vitamin B12 to address the patient's chronic persistent pain of the neck, upper extremities, low back, and lower extremities on 10/31/2013. MTUS and ACOEM Guidelines do not discuss vitamin injections. ODG Guidelines discuss vitamin B stating that this is not recommended for chronic pain. AETNA Guidelines specifically discuss vitamin B12 supplementation stating that these injections are medically necessary only for members with current or previously documented B-12 deficiency along with the diagnosis of anemia, GI disorders, neuropathy, etc. In this case, there are no such documentation. Recommendation is for denial.

#### **Norco 10/325mg, one by mouth every 6-8 hours, #90: Upheld**

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

Criteria For Use of Opioid (On-Going Management).

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

**Decision rationale:** This patient presents with chronic pain syndrome involving neck, upper extremities, low back, and lower extremities. The treating physician has been prescribing Norco for quite sometime. There are only 2 reports provided for this review, 09/30/2013 and 10/31/2013. These reports provide only general statements regarding effectiveness of this medication. MTUS Guidelines page 70 require documentation of the 4As, analgesia, ADL, adverse effects, adverse drug seeking behavior as well as "pain assessment" that include current pain, the least amount of pain, average pain, duration of pain relief with the use of medication. Most of these informations are not provided. While the treating physician has been obtaining urine drug screen on a monthly basis, which partially satisfies aberrant drug seeking behavior and he provides general statements regarding patient's improvement, there were no specifics provided to determine whether or not the patient has experienced "significant improvement" in terms of activities of daily living, significant analgesia has been achieved, etc. Recommendation is for denial and slow weaning of the medication.

**Ambien 10mg, one by mouth at bedtime, #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, Insomnia Treatment.

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

**Decision rationale:** This patient presents with chronic pain syndrome. The treating physician has been prescribing Ambien on a monthly basis to be taken on as needed basis. MTUS and ODG Guidelines clearly do not support chronic use of this medication. If it is used, it is recommended for short term only. In this case, the treating physician appears to be prescribing this medication on a long-term basis. Recommendation is for denial.

**Ultram 50mg, one by mouth every 4-6 hours, as needed, #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (Non-steroidal Anti-inflammatory drugs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS (MTUS ) Page(s): 98, 99.

**Decision rationale:** This patient presents with chronic pain syndrome involving neck, upper extremities, low back, and lower extremities. The treating physician has been prescribing Ultram for quite sometime. There are only 2 reports provided for this review, 09/30/2013 and 10/31/2013. These reports provide only general statements regarding effectiveness of this medication. MTUS Guidelines page 70 require documentation of the 4As, analgesia, ADL, adverse effects, adverse drug seeking behavior as well as "pain assessment" that include current pain, the least amount of pain, average pain, duration of pain relief, use of medication. Most of

these informations are not provided. While the treating physician has been obtaining urine drug screen on a monthly basis, which partially satisfies aberrant drug seeking behavior and he provides general statements regarding patient's improvement, there were no specifics provided to determine whether or not the patient has experienced "significant improvement" in terms of activities of daily living, significant analgesia has been achieved, etc. Recommendation is for denial and slow weaning of the medication.

**Amitramadol-DM Ultracream 4%/20%/10%, apply a thin layer to the affected area 2-3 times daily: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines The MTUS has the following regarding topical creams , chronic pain section) Page(s): 111.

**Decision rationale:** This patient presents with chronic pain syndrome and the treating physician has apparently prescribed amitramadol-DM/Ultracream 4%/20%/10%. MTUS Guidelines provide clear guidance regarding use of topical analgesics. It states that if one of the components of compounded cream is not recommended then the entire compound is not recommended. In this case, tramadol contained in this product is not recommended for topical formulation. Recommendation is for denial.

**Gabaketolido 6%/20%/6.15% cream, apply a thin layer to the affected area twice daily, dosed six (6) hours apart, then withhold for twelve (12) hours: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines The MTUS has the following regarding topical creams , chronic pain section) Page(s): 111.

**Decision rationale:** This patient presents with chronic pain syndrome. The treating physician has prescribed Gabaketolido topical cream. MTUS Guidelines provide clear guidance regarding use of topical analgesics. It states that if one of the components is not recommended then the entire compound is not recommended. In this case, the gabapentin that is contained on this topical compounded product is not recommended as a topical formulation. Recommendation is for denial.