

Case Number:	CM14-0038286		
Date Assigned:	06/25/2014	Date of Injury:	11/01/1998
Decision Date:	08/15/2014	UR Denial Date:	03/14/2014
Priority:	Standard	Application Received:	04/01/2014

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 Internal Medicine, and is licensed to practice in Arizona. 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 is a 61-year-old female with a remote date of injury (1998), where she developed right elbow pain, tingling and numbness in her lateral fingers, later followed by neck pain, and upper back pain. This was felt to be due to the repetitiveness of her work as a customer service representative at a bank. She was treated conservatively with physical therapy and medications, which eventually led to a cervical fusion without benefit. Trigger point injections gave moderate relief. An MRI in 2003 showed stable hardware, an electromyography (EMG) in 2007 showed no cervical or ulnar radiculopathy; but she did have mild carpal tunnel syndrome. She had progressive shoulder pain and in 2003, an MRI revealed a tear at the right shoulder. She then had a rotator cuff repair. She continues with chronic neck pain and associated headaches; her exam shows moderately limited range of motion and tender paraspinals. She requested refills on Terocin cream, which she uses up to 3 times a day, and Ambien Cr 6.25mg #30. She states that even with a full pill she generally sleeps less than 4 hours a night. No other documentation on sleep problems was noted. No discussions on sleep hygiene. It is not known if her sleep issues are secondary to pain, restless legs, etc., or whether any other medications have been tried. She additionally desires authorization for repeat trigger injections. The medications that she has used in the past and failed include Lunesta (ineffective) Flexeril (ineffective), Zanaflex, Skelaxin (ineffective), nortriptyline (dry mouth), Dilaudid, Percocet, (both dry mouth) Celebrex and other NSAIDS (GI Upset), gabapentin and Lyrica (ineffective), Voltaren gel (skin irritation). She apparently has used Soma qhs (positive Lab screen April 2012). Her current medication list does not include Soma. It includes Terocin, promethazine 25mg, Ambien, evamist & triamcinolone sprays.

IMR ISSUES, DECISIONS AND RATIONALES

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

Terocin #2: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 111-113.

Decision rationale: Terocin (methyl salicylate 25%, Capsaicin .025%, Menthol 10%, lidocaine 2.5%) has been requested for her neck, right shoulder and arm pain. She has used this on a prior occasion(s); duration is unknown. Quality of improvement is not known. This is a compounded topical agent and, according to the MTUS, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. These are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as mono therapy or in combination for pain control (including non-steroidal anti-inflammatory drugs (NSAIDs), opioids, capsaicin, local anesthetics, antidepressants, etc. 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 use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required (page 111). Capsaicin .025% can be used in persons with osteoarthritis. Lidocaine however in a cream or gel form is not recommended. The only lidocaine formulation recommended is a dermal patch and has an off-label indication for diabetic neuropathy. The methyl salicylate 25% and the Menthol 10% are neither mentioned in the MTUS or ODG. For the reason that Lidoderm is not recommended as a cream, it is deemed that Terocin is not medically necessary.

Ambien Cr 6.25 mg #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)TWC PAIN.

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

Decision rationale: This complainant previously was given a tapering quantity of Zolpidem CR 6.25mg, #15. I concur with the prior Medical Reviewer who quoted the ODG, which points out, that it is approved for short-term (usually 2-6 weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Other than, the one comment made by the patient that she sleeps less than four hours on the Zolpidem CR, there is no real documentation on her insomnia. I would question if there have been real discussions

regarding good sleep hygiene. Does she take naps, drink caffeine, or alcohol? Why does she think she has trouble sleeping? Is it related to pain? Restless legs? Has there ever been a sleep study? Has she consulted with a sleep specialist? Has any kind of Cognitive behavioral therapy been tried? Was Gabapentin ever maximally dosed with an assessment on its effect on sleep? How long was she on Nortriptyline? What dosage was tried? Has she ever tried the melatonin agonists/? Trazodone? Cymbalta? Doxepin? Mirtazapine? Ambien CR clearly is not adequately working if this complainant still gets less than four hours a night. Pushing the dosage would not be recommended; previously the higher doses were found to have potentially dangerous concentrations in the blood eight hours later, with the CR being more problematic than the IR (Immediate Release). Thus, the FDA now requires lower doses for Zolpidem. Cognitive behavioral therapy (CBT) should be an important part of an insomnia treatment plan. A study of patients with persistent insomnia found that the addition of Zolpidem immediate release to CBT was modestly beneficial during acute (first 6 weeks) therapy, but better long-term outcomes were achieved when Zolpidem IR was discontinued and maintenance CBT continued. It is for these reasons that the request for the ongoing usage of Zolpidem Cr 6.25mg is not medically necessary.