

Case Number:	CM14-0047241		
Date Assigned:	08/08/2014	Date of Injury:	01/26/1999
Decision Date:	09/24/2014	UR Denial Date:	03/21/2014
Priority:	Standard	Application Received:	04/15/2014

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 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 57-year-old female who was injured on 01/26/1999 when she slipped on a chemical spill sustaining injuries to her back, neck and right hip. Prior medication history as of 05/13/2014 included Naproxen 550 mg, pantoprazole sodium 20 mg, hydrocodone 10/325 mg, Zolpidem 10 mg, Flurbiprofen 20%/tramadol 20% in Mediderm base 30 grams, gabapentin 10%; dextromethorphan 10%/amitriptyline 10%; medical creams including gabapentin 10% in mediderm base 210 grams (No VAS provided). The patient's medications as of 03/11/2014 included Norco 10/325, capsaicin 0.025%, flurbiprofen 20%; tramadol 15%; menthol 2%; camphor 2%; Soma 350 mg; tramadol/L-Carnitine 40/125 mg; compound cream (No VAS provided). UA test dated 05/13/2014 revealed consistent results with prescribed medication treatment plan. The presence of UN prescribed medication was detected in the panel TBD urinalysis test. Progress report dated 05/13/2014 indicates the patient presented with moderate right shoulder pain, stiffness, heaviness and weakness. The right hip produces severe pain, stiffness, tingling and cramping. She also complains of constant moderate to severe stabbing left hip pain, stiffness and tingling. The left knee revealed mild to moderate left knee pain, stiffness, and tingling. Objective findings on exam revealed tenderness to palpation of the acromioclavicular joint, anterior shoulder and lateral shoulder. The right hip revealed tenderness to palpation of the anterior hip, lateral hip and posterior hip. The left knee is within normal limits. She is diagnosed with right shoulder impingement syndrome; right shoulder muscle spasm; right shoulder sprain; right hip pain; left hip pain; left hip strain/sprain; left knee sprain/strain. The patient's complaints/symptoms were the same as above on note dated 03/11/2014. Prior utilization review dated 03/21/2014 states the request for Norco 10/325mg (quantity not specified) is denied as it is not medically necessary; Protonix 20mg (quantity not specified) is denied as it is not medically necessary; Soma 350mg (quantity not specified) is

denied as it is not medically necessary; Tramadol/L-Carnitine 40/125mg (quantity not specified) is denied as it is not medically necessary; Capsaicin 0.025%, Flurbiprofen 20%, Tramadol 15%, Menthol 2%, Camphor 2% 10mg Cream; Compound Cream: Flurbiprofen 15% and Cyclobenzaprine 2%; are denied as it is not medically necessary; Compound Cream: Capsaicin 0.025% Flurbiprofen 15%, Tramadol 15%, Menthol 2%, Camphor 2%; and SudoScan is denied as it is not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg (quantity not specified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80.

Decision rationale: According to the CA MTUS guidelines, Norco is indicated for moderate to moderately severe pain. Norco is an "opioid short acting" in chronic pain is recommended for short-term pain relief, the long-term efficacy is unclear (>16 weeks), but also appears limited. Long-term use of opioids for non-malignant pain is not generally recommended. The medical records do not reflect there has been any significant improvement in pain level or functional capacity. One criteria for ongoing chronic opioid use includes: Document pain and functional improvement and compare to baseline. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument. However, the medical records do not reflect there has been any notable benefit with ongoing use. The guidelines state opioids should be discontinued if there is no overall improvement in function. In the absence of documented significant improvement of pain and function on the requested medication, the request is not medically necessary according to the guidelines. The medical records fail to establish ongoing use of Norco is appropriate and clinically indicated. At this juncture, Norco should be discontinued as medical necessity has not been established. The request for Norco 10/325mg (quantity not specified) is not medically necessary.

Protonix 20mg (quantity not specified): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Pain (Chronic), PPI's.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: According to the guidelines, proton pump inhibitor, such as Omeprazole, may be recommended for patients at risk for gastrointestinal events. Determining factors are 1) age over 65 years, 2) history of peptic ulcer, GI bleeding or perforation, 3) concurrent use of ASA, corticosteroids, and/or an anticoagulants, or 4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The medical records do not demonstrate potential risk factors are present in the case of this patient. Furthermore, other PPIs, such as Protonix, should be considered second-line therapy. The medical records do not establish the patient has significant risk factors of GI events and failed to respond to first line PPI. Consequently, the medical necessity of Protonix has not been established. The request for Protonix 20mg (quantity not specified) is not medically necessary.

Soma 350mg (quantity not specified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Page(s): 65.

Decision rationale: According to the guidelines, Soma is not recommended. This medication is not indicated for long-term use. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a schedule-IV controlled substance). Abuse has been noted for sedative and relaxant effects. In addition, there is no evidence of muscle spasms on examination. Regardless, Soma is not recommended under the guidelines. Furthermore, chronic and ongoing use of muscle relaxants is not recommended. The request for Soma 350mg (quantity not specified) is not medically necessary.

Tramadol/L-Carnitine 40/125mg (quantity not specified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80.

Decision rationale: The ODG states compound drugs are not recommended as a first-line therapy for most patients, but recommended as an option after a trial of first-line FDA-approved drugs, if the compound drug uses FDA-approved ingredients that are recommended in ODG. Tramadol is a commercially available medication. L-carnitine is an amino acid naturally produced by the body. There is no indicated medical necessity for supplementation of L-carnitine. According to the Chronic Pain Medical Treatment Guidelines, Tramadol (Ultram) is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic, it is indicated for moderate to severe pain. The guidelines state continued opioid treatment requires documented pain and functional improvement and response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The medical records do not establish these requirements have been met. In review of the

medical records, the medical necessity for this product has not been established. The request for Tramadol/L-Carnitine 40/125mg (quantity not specified) is not medically necessary.

Capsaicin 0.025%, Flurbiprofen 20%, Tramadol 15%, Menthol 2%, Camphor 2% 10mg Cream: Upheld

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

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

Decision rationale: According to the CA MTUS guidelines, topical analgesics are considered to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. The medical records do not establish this patient cannot tolerate oral analgesics, standard conservative measures. Consequently this compounded product is not supported by the evidence based guidelines. The medical necessity is not established. The request for Capsaicin 0.025%, Flurbiprofen 20%, Tramadol 15%, Menthol 2%, Camphor 2% 10mg Cream is not medically necessary.

Compound Cream: Flurbiprofen 15%, Cyclobenzaprine 2%: Upheld

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

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

Decision rationale: According to the CA MTUS guidelines, muscle relaxants, such as cyclobenzaprine, are not recommended in topical formulation. As per the guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Consequently the medical necessity of this topical compound is not established. The request for Compound Cream: Flurbiprofen 15%, Cyclobenzaprine 2% is not medically necessary.

Compound Cream: Capsaicin 0.025%, Flurbiprofen 15%, Tramadol 15%, Menthol 2%, Camphor 2%: Upheld

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

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

Decision rationale: According to the CA MTUS guidelines, topical analgesics are considered to be largely experimental in use with few randomized controlled trials to determine efficacy or

safety. The medical records do not establish this patient cannot tolerate oral analgesics, standard conservative measures. Consequently this compounded product is not supported by the evidence based guidelines. The medical necessity is not established. The request for Compound Cream: Capsaicin 0.025%, Flurbiprofen 15%, Tramadol 15%, Menthol 2%, and Camphor 2% is not medically necessary.

SudoScan: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Calvet, J.H., et al Exp Clin Endocrinol Diabetes 120 (2012): 1-4.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, CRPS, diagnostic tests Other Medical Treatment Guideline or Medical Evidence: <http://us.impeto-medical.com/faq/>.

Decision rationale: CA MTUS/ACOEM guidelines are silent regarding this request SUDOSCAN is a medical device has been cleared by the FDA as a galvanic skin response test. Galvanic Skin Response (GSR) is a change in the electrical properties of the skin in response to different kinds of stimuli. In GSR, changes in the voltage measured from the surface of the skin are recorded. The main origin of the signal has suggested to be the activation of sweat glands (sudomotor function). According to the ODG: Sudomotor measures: Most formal diagnostic tests for this are laboratory based and not generally recommended. Tests include (1) the iontophoretic quantitative sudomotor axon reflex test (QSART), (2) the sialastic sweat imprint method, (3) the thermoregulatory sweat test (TST), (4) sympathetic skin response and related electrodermal activity, (5) sympathetic skin resistance and selective tissue conductance, (6) quantitative sensory testing (QST), (7) resting sweat output (RSO). Per the guidelines, formal diagnostic tests for measuring sudomotor response is not generally recommended. The patient is diagnosed with shoulder impingement, pain and various sprain/strains. The medical records do not provide clinical rationale for this test. The medical necessity of the request is note established and the request for SudoScan is not medically necessary.