

<b>Case Number:</b>	CM14-0074478		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	05/30/2002
<b>Decision Date:</b>	09/19/2014	<b>UR Denial Date:</b>	04/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/21/2014

### 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, and Pain Medicine and is licensed to practice in Texas. 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 47-year-old female injured on May 30, 2002 while performing normal job duties as a Medicare phone representative resulting in industrial injury to her neck, bilateral shoulders, low back, mid back, right knee, and upper and lower extremities. Neither the specific injury sustained nor the initial treatments rendered were discussed in the documentation provided. Diagnoses include cervical spine sprain/strain syndrome, chronic residual symptoms of the left shoulder possible impingement, status post right carpal tunnel release, status post right elbow epicondylectomy with ulnar nerve decompression, lumbar spine strain/sprain syndrome, lumbar disc herniation/protrusion, lumbar facet arthropathy, thoracic radiculopathy, thoracic sprain/strain, and status post right knee surgery x3 with residual pain, acute gastritis, acute bilateral hip and knee pain, depression/anxiety, and insomnia. Clinical note dated April 21, 2014 indicates the injured worker presented complaining of right forearm and hand pain, discomfort of mid to low back radiating to the right buttock, thigh, and feet/toes. The injured worker reported uncertainty if the right leg pain is radiating from the low back or caused by the right knee pain. The injured worker reports pain is exacerbated by prolonged walking and standing. The injured worker reports debilitating pain causing inability to perform her usual and customary work activities and activities of daily living resulting in increased depression and anxiety. Objective findings included inability to perform heel and toe walk, loss of lumbar lordosis, tenderness to palpation of the lumbar spine, restricted and painful range of motion of the lumbar spine, tenderness to palpation of the thoracic spine, restricted range of motion of the thoracic spine, decreased sensation to light touch in the lumbar spine, bilateral hip and knee pain with reduced/painful movement, and depressed affect and mood. The injured worker rated pain at 9/10. Prescriptions for Prilosec OTC 20mg bid, soma 350mg #120 every 6 hours, Rozerem 8mg #30 qhs, Fioricet #90 tid, Percocet 10/325mg #120 qid and Ativan 1mg #45 qd-bid prn were

provided. The initial request for Nucynta ER 50mg #60, Nucynta 50 mg #90, carisoprodol 350 mg #120, butalbital/acetaminophen/caffeine tab #90, hydrocodone/ibuprofen tab 7.5/200 #150, duloxetine cap 60mg #60, clonazepam 2mg #90, compound cream containing flurbiprofen (10%), diclofenac (10%) and tramadol (10%) date of service 03/11/14, and compound cream containing lidocaine (6%), ketoprofen (10%), and gabapentin (10%) date of service 03/11/14 was initially non-certified on 04/18/14.

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

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

**Nucynta ER (50mg, #60): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

**Decision rationale:** As noted in the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of Nucynta ER 50mg #60 cannot be established at this time.

**Nucynta (50mg, #90): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

**Decision rationale:** As noted in the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of Nucynta 50mg #90 cannot be established at this time.

**Carisoprodol (350mg, #120): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary.

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

**Decision rationale:** As noted in the Chronic Pain Medical Treatment Guidelines, Soma is not recommended for long-term use. This medication is FDA-approved for symptomatic relief of discomfort associated with acute pain in musculoskeletal conditions as an adjunct to rest and physical therapy. The documentation indicates that the patient is being prescribed the medication for chronic pain and long-term care exceeding the recommended treatment window. As such, Carisoprodol 350mg #120 cannot be recommended as medically necessary at this time.

**BUT/APAP/CAF tab, #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs) Page(s): 23.

**Decision rationale:** As noted in the Chronic Pain Medical Treatment Guidelines, use of a barbiturate-containing analgesic, is not recommended for treatment of chronic pain. Research indicates the potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy. Additionally, there is no indication in the documentation that establishes the benefits associated with the use of the medication. The clinical notes indicate that the patient's pain and symptoms remain unchanged with the current medication regimen. As such, the continued use of BUT/APAP/CAF tab, #90 cannot be established as medically necessary at this time.

**Hydrocodone/Ibuprofen (7.5/200, #150):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

**Decision rationale:** As noted in the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of Hydrocodone/Ibuprofen 7.5/200 #150 cannot be established at this time.

**Duloxetine cap (60mg, #60):** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine (Cymbalta) Page(s): 44.

**Decision rationale:** As noted in the Chronic Pain Medical Treatment Guidelines, Cymbalta is recommended as an option in first-line treatment of neuropathic pain. Duloxetine (Cymbalta) is a norepinephrine and serotonin reuptake inhibitor antidepressant (SNRIs). It has FDA approval for treatment of depression, generalized anxiety disorder, and for the treatment of pain related to diabetic neuropathy, with effect found to be significant by the end of week 1. The clinical documentation establishes the presence of objective findings consistent with neuropathy and depression. As such, the request for Duloxetine cap 60mg #60 is recommended as medically necessary.

**Clonazepam (2mg, #90):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** As noted in the Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Studies have shown that tolerance to hypnotic effects develops rapidly and tolerance to anxiolytic effects occurs within months. It has been found that long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. As such the request for Clonazepam 2 mg #90 cannot be recommended as medically necessary at this time.

**Compound cream containing Flurbiprofen (10%), Diclofenac (10%) and Tramadol (10%) with a date of service of 3/11/14:** Upheld

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

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

**Decision rationale:** As noted in the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials.

Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Further, California MTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. This compound contains multiple components which have not been approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore, the request for compound cream containing Flurbiprofen (10%), Diclofenac (10%) and Tramadol (10%) with a date of service of 3/11/14 cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

**compound cream containing lidocaine (6%), ketoprofen (10%), and gabapentin (10%) with a date of service of 03/11/14: Upheld**

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

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

**Decision rationale:** As noted in the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Further, California MTUS Guidelines, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. This compound contains multiple components which have not been approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore, the request for a compound cream containing lidocaine (6%), ketoprofen (10%), and gabapentin (10%) with a date of service of 03/11/14 cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.