

Case Number:	CM14-0077779		
Date Assigned:	08/06/2014	Date of Injury:	03/05/2013
Decision Date:	09/17/2014	UR Denial Date:	05/08/2014
Priority:	Standard	Application Received:	05/23/2014

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 & Pain Medicine 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 injured worker is a 58-year-old male with a reported date of injury on 03/05/2013. His diagnoses were noted to include cervical radiculopathy, cervical sprain/strain, lumbar myospasm, lumbar pain, lumbar radiculopathy, lumbar sprain/strain, left shoulder impingement syndrome, left shoulder sprain/strain, right shoulder impingement syndrome, right shoulder pain, right shoulder sprain/strain, and rule out right shoulder internal derangement. The injured worker's previous treatments were noted to include chiropractic treatment, physical therapy, surgery, and medications. The progress note dated 03/04/2014 revealed the injured worker complained of neck pain rated 4/10 that had improved with the last cervical epidural steroid injection, low back pain, left shoulder pain, and right shoulder pain. The injured worker also complained of a loss of sleep due to pain. The ranges of motion were decreased and painful to the cervical spine and there was 3+ tenderness to palpation of the cervical paravertebral muscles. There were muscle spasms of the cervical paravertebral muscles and cervical compression was positive. The lumbar spine examination revealed trigger points and paraspinous lesion at the lumbar spine and ranges of motion were decreased and painful. There was 3+ tenderness to palpation of the lumbar paravertebral muscles along with muscle spasms. There was a positive Kemp's test and straight leg raise test. The physical examination of the left shoulder revealed ranges of motion were decreased and painful and there was 3+ tenderness to palpation on the lateral shoulder, posterior shoulder, supraspinatus and trapezius. The supraspinatus press was positive. The physical examination of the right shoulder revealed decreased and painful ranges of motion with 3+ tenderness to palpation of the acromioclavicular joint, anterior shoulder, lateral shoulder, posterior shoulder, and supraspinatus. The supraspinatus press was noted to be positive. The request for authorization form was not submitted within the medical records. The request was for Flurbiprofen/tramadol (strength and quantity not specified) date of service 03/25/2014 and

gabapentin/amitriptyline/dextromethorphan (strength and quantity not specified) date of service 03/25/2014 for orthopedic recovery surgery, hydrocodone/APAP 10/325 mg (quantity not specified) date of service 03/19/2014 for pain, zolpidem tartrate (quantity not specified) date of service 03/19/2014 for sleep.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen/Tramadol (Strength and Quantity Not Specified) Date of Service: 3/25/14:
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): 111-112.

Decision rationale: The request for Flurbiprofen/Tramadol (Strength and Quantity Not Specified) Date of Service: 3/25/14 is not medically necessary. The injured worker has been utilizing this medication since 03/25/2014. The California Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines recommend topical analgesics for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The guidelines state the efficacy and clinical trials for topical NSAIDs have been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2 week period. When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. In this study, the effect appeared to diminish over time and it was stated that further research was required to determine if results were similar for all preparations. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. The guidelines indications for topical NSAIDs are osteoarthritis and tendonitis, in particular, that of the knee and elbow, or other joints that are amenable to topical treatment for short-term use (4 to 12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. The guidelines do not recommend topical NSAIDs for neuropathic pain as there is no evidence to support use. There is lack of documentation regarding the injured worker being diagnosed with osteoarthritis to warrant topical NSAIDs. The ingredient tramadol is recommended as an oral medication. There is a lack of documentation regarding the injured worker unable to consume oral medications. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.

Gabapentin/Amitriptyline/Dextromethorphan (Strength and Quantity Not Specified) Date of Service: 3/25/14: 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): 111-113.

Decision rationale: The request for Gabapentin/Amitriptyline/Dextromethorphan (Strength and Quantity Not Specified) Date of Service: 3/25/14 is not medically necessary. The injured worker has been utilizing this medication since at least 03/25/2014. The Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines primarily recommended topical analgesics for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended as a topical analgesic as there is no peer reviewed literature to support use. Amitriptyline is an antidepressant recommended for oral use and Dextromethorphan is a cough suppressant recommended for oral utilization. The guidelines state any compounded agent that contains at least 1 drug (or drug class) that is not recommended is not recommended and gabapentin, amitriptyline, and Dextromethorphan are not recommended for topical analgesic utilization. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.

Hydrocodone/APAP 10/325 mg (Quantity Not Specified), Date of Service: 3/19/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: The request for Hydrocodone/APAP 10/325 mg (Quantity Not Specified), Date of Service: 3/19/14 is not medically necessary. The injured worker has been utilizing this medication since at least 03/19/2014. According to the California Chronic Pain Medical Treatment Guidelines, the ongoing use of opioid medications may be supported with detailed documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines also state that the 4 A's for ongoing monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors should be addressed. There is a lack of documentation regarding decreased pain on a numerical scale with the use of medications. There is a lack of documentation regarding improved functional status with activities of daily living with the use of medication. There were no adverse effects with the use of medications noted. The documentation did not indicate the injured worker had not shown any aberrant behaviors and there is a lack of documentation regarding whether the injured worker has had consistent urine drug screens and when the last test was performed. Therefore, due to the lack of evidence of significant pain relief, increased function, side effects, and without details

regarding urine drug testing to verify appropriate medication use in the absence of aberrant behavior, the ongoing use of opioid medications it not supported by the guidelines. Additionally, the request failed to provide the frequency at which this medication is to be utilized. As such, the request is not medically necessary.

Zolpidem Tartrate 10 mg (Quantity not Specified) Date of Service 3/19/14: 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, Insomnia Mosby's Drug Consult.

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

Decision rationale: The request for Zolpidem Tartrate 10 mg (Quantity not Specified) Date of Service 3/19/14 is not medically necessary. The injured worker complained of loss of sleep due to pain. The Official Disability Guidelines state zolpidem is a prescription short acting no benzodiazepine hypnotic, which is approved for the short-term (usually 2 to 6 weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and is often hard to obtain. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. There is a lack of documentation regarding sleep quality and duration to warrant zolpidem. Additionally, there was a lack of documentation regarding the efficacy of this medication and the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.