

Case Number:	CM14-0156023		
Date Assigned:	09/25/2014	Date of Injury:	11/28/2000
Decision Date:	09/29/2015	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	09/23/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Emergency Medicine

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 46 year old female, who sustained an industrial injury on 11-28-2000 secondary to repetitive bending and lifting resulting in neck, mid back, bilateral shoulders, bilateral wrists pain and insomnia. On most recent provider visit dated 05-13-2014 the injured worker has reported neck pain to the upper extremities with numbness and tingling, constant mid back pain, bilateral shoulder pain, wrist-hand pain. Pain without medication was noted as 8 out of 10 and pain with medication was noted as 3 out of 10. On examination the cervical spine revealed decreased range of motion and spasms. Bilateral shoulders, bilateral wrists and thoracic range of motion were noted as decreased. The diagnoses have included cervical spinal stenosis, thoracic sprain-strain, right shoulder partial rotator cuff tear, left shoulder tendinitis, and bilateral carpal tunnel syndrome and adjustment disorder. Treatment to date has included medication and physical therapy. The provider requested Tramadol, Omeprazole, Terocin, Flurbi, Methoderm Gel, Xolinda cream and Gabaclotram cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50mg, #60 x 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Opioid use for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 80-83 of 127.

Decision rationale: Tramadol is a pain medication in the category of a centrally acting analgesic. They exhibit opioid activity and a mechanism of action that inhibits the reuptake of serotonin and norepinephrine. Centrally acting drugs are reported to be effective in managing neuropathic type pain although it is not recommended as first line therapy. The side effect profile is similar to opioids. For chronic back pain, it appears to be efficacious for short term pain relief, but long term (>16 weeks) results are limited. It also did not appear to improve function. The use of tramadol for osteoarthritis is indicated for short term use only (<3 months) with poor long-term benefit. In this case, the patient does not meet the qualifying criteria. This is secondary to the duration of use, with this medication being indicated on a short-term basis only. As such, the request is not medically necessary.

Omeprazole 20mg, #60 x 3 refills: 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 Procedure Summary; Proton Pump Inhibitors (PPI's).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 68 of 127.

Decision rationale: The request is for the use of a medication in the class of a proton pump inhibitor. It is indicated for patients with peptic ulcer disease. It can also be used as a preventative measure in patients taking non-steroidal anti-inflammatories for chronic pain. Unfortunately, they do have certain side effects including gastrointestinal disease. The MTUS guidelines states that patients who are classified as intermediate or high risk, should be treated prophylactically. Criteria for risk are as follows: "(1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)." Due to the fact the patient does not meet to above stated criteria, the request for use is not medically necessary.

Terocin lotion x 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 111-112 of 127.

Decision rationale: The request is for the use of a topical NSAID for pain relief. There are specific criteria require for use based on the guidelines. The MTUS states the following: The

efficacy in clinical trials for this treatment modality has 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. (Lin, 2004) (Bjordal, 2007) (Mason, 2004) When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. FDA-approved agents: Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. In this case, as indicated above, the patient would not qualify for the use of this medication based on the treatment duration. As such, the request is not medically necessary.

Gabaclyotram cream x 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111 to 113 of 127.

Decision rationale: The request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients which each have specific properties and mechanisms of action. The MTUS guidelines state the following: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, the use of gabapentin is stated to be not indicated for use for the patient's condition. The guidelines state the following: "Gabapentin: Not recommended. There is no peer-reviewed literature to support use." As such, the request is not medically necessary.

Menthoderm gel x 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112 of 127.

Decision rationale: The request is for the use of a topical NSAID for pain relief. There are specific criteria require for use based on the guidelines. The MTUS states the following: The efficacy in clinical trials for this treatment modality has 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. (Lin, 2004) (Bjordal, 2007) (Mason, 2004) When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. FDA-approved agents: Voltaren Gel 1% (diclofenac):

Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. In this case, as indicated above, the patient would not qualify for the use of this medication based on the treatment duration. As such, the request is not medically necessary.

Xolinda cream x 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112 of 127.

Decision rationale: The request is for the use of topical lidocaine. The MTUS guidelines state the following: Lidocaine Indication: Neuropathic pain: Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Non-dermal patch formulations are generally indicated as local anesthetics and anti-pruritics. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. In this case, as stated above, the patient does not meet the criteria for use of this product in this formulation. There is a requirement of documentation of a first-line therapy trial prior to use of a lidocaine dermal patch. There is also no other commercially approved topical formulations of lidocaine indicated for neuropathic pain other than Lidoderm. As such, the request is not medically necessary.

Flurbi (NAP) cream - 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112 of 127.

Decision rationale: The request is for the use of a topical NSAID for pain relief. There are specific criteria require for use based on the guidelines. The MTUS states the following: The efficacy in clinical trials for this treatment modality has 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. (Lin, 2004) (Bjordal, 2007) (Mason, 2004) When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. FDA-approved agents: Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. In this case, as indicated above, the patient would not qualify for the use of this medication based on the treatment duration. As such, the request is not medically necessary.