MAXIMUS Federal Services

Case Number:	CM14-0204601		
Date Assigned:	12/16/2014	Date of Injury:	06/07/2013
Decision Date:	02/24/2015	UR Denial Date:	11/25/2014
Priority:	Standard	Application Received:	12/05/2014

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: Maryland
Certification(s)/Specialty: Physical Medicine & Rehabn, Neuromuscular 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 patient is a 45 year old female who had a work injury dated 6/7/13. The diagnoses include rotator cuffstrain; shoulder jolnt pain. She underwent a diagnostic and operative arthroscopy of the right shoulder with Bankart repair,partial synovectomy, removal of loose bodies, lysis of adhesions, subacromial bursectomy on 10/1/13. Acupuncture QTY 30; Orphenadrine/Caffeine 50/10mg capsules QTY 60; Gabapentin/Pyridoxine 250/10mg capsules QTY 60; Omeprazole/Flurbiprofen 10/100mg capsules QTY 60; Flurbiprofen/Cyclo/Mentho 20% 10% 14% cream 180mg QTY1; Keratek Gel 4oz QTY 1; Diclofenac/Lidocaine 3% 5% 180mg.There is an 11/12/14 primary treating physician progress report (PR-2) that states that the patient continues to have pain and muscle spasms to the shoulder. On a scale from 1-10, 10 being the worst, she states that her pain is a 6. On exam the patient remains symptomatic to the right shoulder with stiffness, limited range of motion and weakness to the internal and external rotation. X-rays of the right shoulder and right humerus show no increase in osteoarthritis. The treatment plan includes authorization for 30 visits of acupuncture to the right shoulder; urine toxicology. She was given a prescription for the medications and creams under consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture qty 30: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Acupuncture qty 30 is not medically necessary as written per the MTUS guidelines. The MTUS Acupuncture Medical Treatment Guidelines recommend that the time to produce functional improvements is 3-6 treatments and acupuncture treatments may be extended if functional improvement is documented. The request as written would exceed the recommended number of visits. Therefore, acupuncture qty 30 is not medically necessary.

Orphenadrine/Caffeine 50/10mg capsules qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Compounded Topical Analgesic Creams

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Orphenadrine Page(s): 65. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Pain section; Complementary, alternative treatments, or dietary supplements, etc., Chapter 7 page 135 Official Disability Guidelines (ODG) Pain (Chronic)- Medical food

Decision rationale: Orphenadrine/Caffeine 50/10mg capsules qty 60 are not medically necessary per the MTUS and the ODG Guidelines. The MTUS states that Orphenadrine is a muscle relaxant. The updated ACOEM and the ODG guidelines state that medical foods are not recommended for treatment of chronic pain as they have not been shown to produce meaningful benefits or improvements in functional outcomes. The documentation is not clear on why the patient would require this in conjunction with caffeine which can be considered a medical food and is not recommended for chronic pain. The request for Orphenadrine/Caffeine 50/10mg capsules qty 60 is not medically necessary.

Gabapentin/Pyridoxine 250/10mg capsules qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), compounded topical analgesics creams

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 49. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Pain section; Complementary, alternative treatments, or dietary supplements, etc., Chapter 7 page 135 Official Disability Guidelines (ODG) Pain (Chronic)- Medical food; Carpal Tunnel Syndrome- Vitamin B6 (pyridoxine)

Decision rationale: Gabapentin/Pyridoxine 250/10mg capsules qty 60 are not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that Gabapentin is first line for neuropathic pain. The updated ACOEM and the ODG guidelines state that medical foods are not recommended for treatment of chronic pain as they have not been shown to produce meaningful benefits or improvements in functional outcomes. The ODG states that Vitamin B6 (pyridoxine) is often used in carpal tunnel syndrome when it is perceived to be deficient, but this practice is not consistently supported by the medical evidence. The documentation does not indicate evidence suggestive of neuropathic pain or vitamin deficiency that would necessitate Gabapentin/Pyridoxine 250/10mg. Therefore, this request is not medically necessary.

Omeprazole/Flurbiprofen 10/100mg capsules qty 60: 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) Treatment in Workers Compensation (TWC)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flurbiprofen; NSAIDs, GI symptoms & cardiovascular risk Page(s): 72; 68-69.

Decision rationale: Omeprazole/Flurbiprofen 10/100mg capsules qty 60 are not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that Flurbiprofen is an NSAID and can be used for osteoarthritis and mild to moderate pain. The guidelines state that the patient is at risk for gastrointestinal events if they meet the following criteria (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). The guidelines also state that a proton pump inhibitor can be considered if the patient has NSAID induced dyspepsia. The documentation does not indicate that the patient meets the criteria for a proton pump inhibitor. Therefore, the request for Omeprazole/Flurbiprofen 10/100 mg capsules qty 60 is not medically necessary.

Flurbiprofen/Cyclo/Mentho 20% 10% 14% cream 180mg qty 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate topical;Topical analgesics Page(s): 105; 111-113.

Decision rationale: Flurbiprofen/Cyclo/Mentho 20% 10% 14% cream 180mg qty 1 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that topical NSAIDs are indicated in osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment and are 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. The guidelines state that topical muscle relaxants are

not recommended as there is no peer-reviewed literature to support use. Menthol is an ingredient in Ben Gay which is a methyl salicylate and supported by the MTUS. The guidelines additionally add that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The documentation does not indicate oral medication intolerance. Furthermore, the guidelines do not support topical Cyclobenzaprine. Therefore, the entire product of Flurbiprofen/Cyclo/Mentho 20% 10% 14% cream 180mg qty 1 is not medically necessary.

Keratek gel 4oz qty 1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Menthol, Topical analgesics Page(s): 105; 111, 112.

Decision rationale: Keratek gel 4oz qty 1 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. Keratek is a compounded gel that contains methyl salicylate and menthol. These are the same ingredients contained in ultra strength Ben Gay. The MTUS states that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no documentation that he has failed oral antidepressants or anticonvulsants. The request for Keratek gel 4oz qty 1 is not medically necessary.

Diclofenac/Lidocaine 3% 5% 180mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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

Decision rationale: Diclofenac / Lidocaine 3%, 5%, 180gm is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that Lidocaine is not indicated in cream, lotion or gel form for neuropathic pain. The guidelines state that Diclofenac is 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. The documentation indicates that the patient suffers from shoulder pain for which Diclofenac would not be indicated topically. The guidelines additionally add that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical Lidocaine is not recommended in this case. The documentation does not indicate oral medication intolerance. Therefore, the request for topical medication Diclofenac / Lidocaine 3%, 5%, 180gm is not medically necessary.