

Case Number:	CM14-0206494		
Date Assigned:	12/18/2014	Date of Injury:	02/26/2003
Decision Date:	02/06/2015	UR Denial Date:	12/01/2014
Priority:	Standard	Application Received:	12/10/2014

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 Internal Medicine and is licensed to practice in New York. 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 47 year old female with a date of injury of 02/26/2003. She injured her shoulders and wrists. On 08/20/2014 and on 09/10/2014 she had bilateral wrist pain. Bilateral Tinel's sign and Phalen's sign were present. During both office visits she received steroid injections. On 10/17/2014 it was noted that the steroid injection helped the right carpal tunnel syndrome. Again, Phalen's sign and Tinel's sign were present bilaterally. On 11/12/2014 the right Tinel's sign was no longer present. She again was treated with steroid injection for the left carpal tunnel syndrome. On 12/03/2014 it was again noted that she had bilateral carpal tunnel syndrome and both Tinel's sign and Phalen's sign were present bilaterally. She had numbness and pain in both hands.

IMR ISSUES, DECISIONS AND RATIONALES

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

30 Ambien 10mg: 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)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Ambien FDA approved package insert.

Decision rationale: MTUS is silent about the use of Ambien. There is no documentation of insomnia in any of the records provided for review. Thus, there is no FDA approved indication for Ambien. Also, the patient is a female and recently there has been a dose change for Ambien in females. It was noted that females taking Ambien each night had an increased drug level. The new maximum dose of Ambien for a female is 5 mg not the 10 mg prescribed. Ambien 10 mg is not medically necessary for this patient based on the documentation provided for review.

60 Prilosec 20mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS - GI and Cardiovascular Risk Page(s): 68 - 69. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Prilosec FDA approved package insert.

Decision rationale: There is no documentation of GERD, peptic ulcer disease, GI bleed or higher risk of bleeding because the patient is 65 years of age or older or taking anticoagulants. There is no documentation that she had a high risk of bleeding. There was a request for additional Anaprox but this was non-certified pending more clinical documentation. Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 68. NSAIDs, GI symptoms & cardiovascular risk. Recommend with precautions as indicated below. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (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). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions. Recommendations Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease:(1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. The patient does not meet high risk for GI bleed criteria for a PPI.

30gm of Flurbiprofen/Lidocaine cream: Upheld

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

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

Decision rationale: Topical Analgesics Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. [Note: Topical analgesics work locally underneath the skin where they are applied. These do not include transdermal analgesics that are systemic agents entering the body through a transdermal means. See Duragesic (fentanyl transdermal system).] Non-steroidal antiinflammatory agents (NSAIDs): 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. On page 112, it is noted that Lidocaine cream is not recommended. Neither is the NSAIDs component of this compound medication. Thus, the entire compound is not recommended.