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| Case Number: | CM15-0192075 | | |
| Date Assigned: | 10/06/2015 | Date of Injury: | 08/03/2004 |
| Decision Date: | 12/09/2015 | UR Denial Date: | 09/03/2015 |
| Priority: | Standard | Application Received: | 09/30/2015 |

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: Preventive Medicine, Occupational 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 71 year old female, who sustained an industrial injury on 8-3-2004. The injured worker was being treated for left shoulder impingement syndrome likely with rotator cuff tear, status post surgery in 2006; right shoulder internal derangement, status post arthroscopy and rotator cuff repair; bilateral knee internal derangement; right carpal tunnel syndrome; and status post left shoulder surgery in 2012. On 8-20-2015, the injured worker reported aching pain of the low back and right knee. The primary treating physician noted that the injured worker's shoulder was "doing reasonably well". Her pain was rated: low back 10 out of 10 and left knee 9 out of 10. Current medications include Hydrocodone and Ketoprofen 20% gel. She reported that she had not gotten her medications. The physical exam (8-20-2015) revealed an antalgic gait, sacroiliac tenderness, lower lumbar midline and paraspinal musculature pain, mild muscle spasm on forward flexion, and 10 degrees of extension on stress of the pelvis. There was 10 degrees of forward flexion, 10 degrees of extension, and 15 degrees of right and left tilt. There was intact hip range of motion with maximum flexion producing sacroiliac region and low back pain. There was abnormal tracking of the left knee patella, a positive patellar grind maneuver, medial aspect tenderness to palpation, and no instability of the left knee. There was normal left knee range of motion and slight weakness on extension due to mild pain. The injured worker was administered a non-steroidal anti-inflammatory intramuscular injection during this visit. Diagnostic studies were not included in the provided medical records. Treatment has included home exercises with massage and medications including oral and topical. Per the treating physician (8-20-2015 report), the injured worker is not working. On 8-20-2015, the requested treatments included

Tramadol-APAP 37.5-325mg; Diclofenac sodium XR 100mg; Flurbiprofen 10%, Diclofenac 10%, Gabapentin 10%, Lidocaine 5% cream; and 8 visits of acupuncture. On 9-3-2015, the original utilization review non-certified requests for Tramadol-APAP 37.5-325mg #60 with 3 refills; Diclofenac sodium XR 100mg #60 with 3 refills; Flurbiprofen 10%, Diclofenac 10%, Gabapentin 10%, Lidocaine 5% cream 180gm; and 8 visits of acupuncture.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol/APAP 37.5/325mg #60 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain, Weaning of Medications.

Decision rationale: Tramadol is a central acting synthetic opioid that exhibits opioid activity with a mechanism of action that inhibits the reuptake of serotonin and norepinephrine with side effects similar to traditional opioids. The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. In this case, there is a lack of significant pain relief or objective evidence of functional improvement with the prior use of this medication. Additionally, this request for 3 refills does not imply close monitoring for efficacy, side-effects or compliance of medication use. It is not recommended to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to continue treatment. The request for Tramadol/APAP 37.5/325mg #60 with 3 refills is determined to not be medically necessary.

Diclofenac sodium XR 100mg #60 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: The use of NSAIDs is recommended by the MTUS Guidelines with precautions. NSAIDs are recommended to be used secondary to acetaminophen, and at the lowest dose possible for the shortest period in the treatment of acute pain or acute exacerbation of chronic pain as there are risks associated with NSAIDs and the use of NSAIDs may inhibit the

healing process. The injured worker has chronic injuries with no change in pain level and no acute injuries reported. Additionally, there is a lack of objective evidence of significant pain relief or functional improvement with the prior use of this medication. Additionally, this request for 3 refills indicates continued chronic use which is not supported by the guidelines. The request for Diclofenac sodium XR 100mg #60 with 3 refills is determined to not be medically necessary.

Flurbiprofen 10%, Diclofenac 10%, Gabapentin 10%, Lidocaine 5% cream 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs), Topical Analgesics.

Decision rationale: The MTUS Guidelines recommend the use of topical analgesics as an option for the treatment of chronic pain, however, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Topical NSAIDs have been shown to be superior to placebo for 4-12 weeks for osteoarthritis of the knee. Topical flurbiprofen is not an FDA approved formulation. Topical NSAIDs have been shown to be superior to placebo for 4-12 weeks for osteoarthritis of the knee. Diclofenac is supported for knee pain. The MTUS guidelines do not recommend the use of topical gabapentin as there is no peer-reviewed literature to support use. Topical lidocaine is used primarily for neuropathic pain when trials of antidepressant and anticonvulsants have failed. The FDA for neuropathic pain has designated topical lidocaine, in the formulation of a dermal patch (Lidoderm) for orphan status. 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. As at least one of the medications in the requested compounded medication is not supported by the guidelines, the request for Flurbiprofen 10%, Diclofenac 10%, Gabapentin 10%, Lidocaine 5% cream 180gm is determined to not be medically necessary.

Acupuncture 8 visits: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: The MTUS Guidelines recommend the use of acupuncture in the treatment of chronic pain. An initial three to six treatments at a frequency of one to three times per week is sufficient to produce functional improvements. If functional improvement results from the use of acupuncture treatments, then they may be extended. The optimum duration of acupuncture treatments is one to two months. In this case, there is no documentation of the efficacy of prior acupuncture treatments. Additionally, this request for 8 sessions of acupuncture exceeds the recommendations of the guidelines. The request for acupuncture 8 visits is determined to not be medically necessary.