

Case Number:	CM15-0029379		
Date Assigned:	02/23/2015	Date of Injury:	01/01/1994
Decision Date:	04/09/2015	UR Denial Date:	02/13/2015
Priority:	Standard	Application Received:	02/18/2015

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: Physical Medicine & Rehabilitation

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 48 year old female, who sustained an industrial injury on 1/1/1994. The diagnoses have included overuse syndrome upper extremities (extensor tendinitis) and carpal tunnel syndrome. Treatment to date has included medication. According to the Primary Treating Physician's Progress Report dated 1/19/2015, the injured worker had a chief complaint of bilateral upper extremity pain. She complained that her hands were getting weaker and she was dropping things more often. She described a constant burning in both hands. Current medications included Ultram, Tylenol and Aleve, Biofreeze, Lidoderm patches, Motrin and protonix. Pain in the bilateral upper extremities was rated as 7/10. Physical exam revealed tenderness over the right index finger and along the metacarpal phalangeal joint. She had decreased sensation to the thumbs bilaterally. On 2/13/2015, Utilization Review (UR) non-certified requests for Biofreeze (as needed), Lidoderm Patches (two patches right arm, 12 hours on and 12 hours off), Protonix 40mg (one every morning) and Tramadol 50mg (two tablets four times a day). The Medical Treatment Utilization Schedule (MTUS) and Official Disability Guidelines (ODG) were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Biofreeze (prn): 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), Low Back Chapter, Biofreeze cryotherapy gel, <http://www.drugs.com/otc/113018/pain-relieving.html>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low Back chapter: Biofreeze cryotherapy gel.

Decision rationale: This patient presents with bilateral upper extremity pain. The treater has asked for BIOFREEZE PRN on 1/19/15. The patient has been using biofreeze since 8/29/14. Regarding biofreeze cryotherapy gel, ODG recommends as an optional form of cryotherapy for acute pain for the low back. ODG further states: "Recommended as an optional form of cryotherapy for acute pain. See also Cryotherapy, Cold/heat packs. Biofreeze is a non-prescription topical cooling agent with the active ingredient menthol that takes the place of ice packs. Whereas ice packs only work for a limited period of time, Biofreeze can last much longer before reapplication. This randomized controlled study designed to determine the pain-relieving effect of Biofreeze on acute low back pain concluded that significant pain reduction was found after each week of treatment in the experimental group. (Zhang, 2008)" The patient has a chronic pain condition. Given the patient's persistent lower back pain, and relatively cost-effectiveness of this gel, the request may be reasonable to treat acute flare-up's. However none of the reports described how it is being used and with what effectiveness. The request IS NOT medically necessary.

Lidoderm Patches (two patches right arm, 12 hrs on, 12 hrs off): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Topical Analgesics Page(s): 56-57, 111-113. Decision based on Non-MTUS Citation Official disability guidelines Pain chapter, Lidoderm.

Decision rationale: This patient presents with bilateral upper extremity pain. The treater has asked for LIDODERM PATCHES PTS R ARM on 1/19/15. Patient has been using Lidoderm since 8/29/14. The treater has ordered the patient to use Lidoderm patches 5% two patches to right arm, 12 hours on, 12 hours off per 1/19/15 report. MTUS guidelines page 57 states, "topical lidocaine may be 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)." MTUS Page 112 also states, "Lidocaine Indication: Neuropathic pain Recommended for localized peripheral pain." When reading ODG guidelines, it specifies that lidoderm patches are indicated as a trial if there is "evidence of localized pain that is consistent with a neuropathic etiology." ODG further requires documentation of the area for treatment, trial of a short-term use with outcome documenting pain and function. In this case, the patient has chronic pain of the bilateral upper extremities. The patient has been using Lidoderm patches for 4 months without documentation of its efficacy. MTUS page 60 require documentation of function and pain reduction when medications are used for chronic pain. More importantly, the

patient does not present with localized neuropathic pain. The patient has diffuse upper extremity pain, and shoulder musculoskeletal pain for which topical lidocaine is not supported. The request IS NOT medically necessary.

Protonix 40mg (one q am): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Proton Pump Inhibitors (PPIs), and Pantoprazole (Protonix), www.drugs.com/cdl/Pantoprazole.htm.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Pain chapter, section on Proton Pump Inhibitors.

Decision rationale: This patient presents with bilateral upper extremity pain. The treater has asked for PROTONIX 40MG on 1/19/15. The patient has been using Protonix since 8/29/14 report. Regarding Protonix, ODG indicates as second-line use for GERD symptoms if trials of Prilosec or Prevacid have failed. Regarding PPIs, MTUS does not recommend routine prophylactic use along with NSAID unless GI risk assessment is provided that include age >65, concurrent use of ASA, anticoagulants, high dose NSAID, or history of bleeding ulcers, PUD, etc. In this case, current list of medications do include an NSAID. There are no documentation of any GI issues such as GERD, gastritis or PUD for which a PPI may be indicated. The patient has been taking a PPI for 4 months, and the treater does not discuss why this medication should be continued. There is no GI risk assessment to warrant a prophylactic use of a PPI. The request IS NOT medically necessary.

Tramadol 50mg (two tablets qid): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, and Specific Drug List, Tramadol (Ultram).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: This patient presents with bilateral upper extremity pain. The treater has asked for TRAMADOL 50MG on 1/19/15. Patient has been using Tramadol since 8/29/14 report. For chronic opioids use, MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. The patient's disability status states: "future medical care" per 1/19/15 report. In this case, the treater does not indicate a decrease in pain with current medications which include Tramadol. There is no discussion of this medication's efficacy in terms of functional improvement using numerical

scale or validated instrument. Quality of life change, or increase in specific activities of daily living are not discussed. There is no discussion of return to work or change in work status attributed to the use of the opiate. Urine toxicology report on 11/20/14 showed negative for all medications tested including Tramadol, as the patient had been denied Tramadol since before the 8/29/14 report. No other aberrant behavior monitoring is provided such as CURES report. Given the lack of sufficient documentation regarding chronic opiates management as required by MTUS, a slow taper off the medication is recommended at this time. The request IS NOT medically necessary.