

Case Number:	CM15-0050863		
Date Assigned:	03/24/2015	Date of Injury:	01/06/2014
Decision Date:	05/15/2015	UR Denial Date:	02/17/2015
Priority:	Standard	Application Received:	03/17/2015

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: New York
 Certification(s)/Specialty: Anesthesiology

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 male, who sustained an industrial injury on 01/06/2014, she report pain in hands, wrists, fingers, shoulder's and back. On provider visit dated 02/05/2015 the injured worker has reported right shoulder pain with weakness and right wrist pain that radiates to fingers. Right shoulder range of motion was decreased. And tenderness to palpation was noted on anterior shoulder. The diagnoses have included right shoulder impingement syndrome and right wrist pain. Treatment to date has included medication, physical therapy acupuncture and MRI. The provider requested topical cream, Tramadol for pain, laboratory studies, Cyclobenzaprine for pain, Naproxen for pain and inflammation and Protonix for gastritis.

IMR ISSUES, DECISIONS AND RATIONALES

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

**Gabapentin 10%/Amitriptyline 10%/ Bupivacaine 5%/Flurbiprofen 20%/Baclofen 10%/
 Dexamethasone 2% 180gms, quantity 30: Upheld**

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

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

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (for example including, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics and/or antidepressants). Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the topical analgesic compound contains: Gabapentin 10%/ Amitriptyline 10%/ Bupivacaine 5%/Flurbiprofen 20%/Baclofen 10%/ Dexamethasone 2%. In this case, there is no documentation provided necessitating this compounded topical analgesic. There is no documentation of intolerance to other previous oral medications. Flurbiprofen, used as a topical NSAID, has been shown to be superior to placebo during the first two weeks of treatment for osteoarthritis, but either not afterward, or with diminishing effect over another two-week period. Gabapentin is not recommended as a topical agent per CA MTUS Guidelines. Medical necessity for the requested topical medication has not been established. The requested treatment is not medically necessary.

Tramadol Extended Release 100mg quantity 45: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 93-94; 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 93-96.

Decision rationale: According to the California MTUS, Tramadol is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain, last reported pain over the period since last assessment, average pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there has been no documentation of this medication's analgesic effectiveness or functional improvement. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic requires a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

Cyclobenzaprine 7.5mg quantity 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 64-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: According to the reviewed literature, Cyclobenzaprine (Flexeril) is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. In addition, this medication is not recommended to be used for longer than 2-3 weeks. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory medications alone. In this case, the available records show that the patient has not shown a documented benefit or any functional improvement from prior Cyclobenzaprine use and there are no muscle spasms documented on the physical exam. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested treatment is not medically necessary.

Protonix 20mg quantity 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non Steroidal Anti Inflammatory Drugs. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment, Pain (Chronic).

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

Decision rationale: According to CA MTUS (2009), proton pump inhibitors, such as Protonix (Pantoprazole), are recommended for patients at risk for gastrointestinal events or taking NSAIDs with documented GI distress symptoms. There is no documentation indicating the patient has any GI symptoms or GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. There is no documentation of any reported GI complaints. Based on the available information provided for review, the medical necessity for Protonix has not been established. The requested medication is not medically necessary.