

Case Number:	CM15-0059419		
Date Assigned:	04/03/2015	Date of Injury:	04/02/2008
Decision Date:	05/05/2015	UR Denial Date:	03/16/2015
Priority:	Standard	Application Received:	03/30/2015

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: Family Practice

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 64 year old female who sustained an industrial injury on 04/02/2008. Diagnoses include status post left shoulder surgery twice for rotator cuff tear and impingement with residual pain and stiffness with recurrent tear of the supraspinatus tendon, right shoulder rotator cuff tear and impingement, cervical and upper thoracic sprain/strain, depression and anxiety, and non-industrial hypertension and diabetes. She has difficulty with adjustment to pain and disability. Treatment to date has included diagnostic studies, physical and massage therapy, home exercise program, and medications. A physician progress note dated 02/10/2015 documents the injured worker has pain in her shoulder, neck and upper back. Surgery has been recommended but the injured worker wants to avoid surgery unless she cannot tolerate the pain. Both shoulders hurt. She has some relief with her medications, which enable her to do her activities at home. She does have more anxiety and trouble sleeping. She has tender trapezius/shoulder, left more than the right. The treatment plan is for medications, urine drug screening and to continue independent program. Treatment requested is for Hydrocodone 10/325 #120, and Trolamine cream 10%.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 10/325 #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78, 80.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the long-term use of opioids, including hydrocodone. These guidelines have established criteria on the use of opioids for the ongoing management of pain. Actions should include: prescriptions from a single practitioner and from a single pharmacy. The lowest possible dose should be prescribed to improve pain and function. There should be an ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. Pain assessment should include: current pain, the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. There should be evidence of documentation of the "4 A's for Ongoing Monitoring." These four domains include: pain relief, side effects, physical and psychological functioning, and the occurrence of any potentially aberrant drug-related behaviors. Further, there should be consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain that does not improve on opioids in 3 months. There should be consideration of an addiction medicine consult if there is evidence of substance misuse (Pages 76-78). Finally, the guidelines indicate that for chronic back pain, the long-term efficacy of opioids is unclear. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy (Page 80).Based on the review of the medical records, there is insufficient documentation in support of these stated MTUS/Chronic Pain Medical Treatment Guidelines for the ongoing use of opioids. There is insufficient documentation of the "4 A's for Ongoing Monitoring." The treatment course of opioids in this patient has extended well beyond the timeframe required for a reassessment of therapy. In summary, there is insufficient documentation to support the chronic use of an opioid in this patient. Treatment with hydrocodone 10/325 mg # 120 is not considered as medically necessary.

Trolamine cream 10%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics and Topical Salicylates Page(s): 111 and 105.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of topical analgesics including topical salicylates (such as Trolamine Cream) as a treatment modality. Topical analgesics are recommended as an option as indicated below. They are 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. Topical salicylates are generally recommended (e.g., Ben-Gay, methyl salicylate) and may be better than placebo in chronic pain. In this case, there is insufficient documentation of the precise indication for the use of Trolamine Cream. If it is intended for neuropathic pain, then there is insufficient evidence that the patient received and failed an adequate course of an antidepressant or anticonvulsant. If the use of Trolamine cream is for chronic, non-neuropathic pain, the records suggest that the patient has been using this regimen for a number of months without evidence of objective benefit; either in reduction of the severity of pain symptoms or reduction in the use of other analgesic medications. For these reasons, Trolamine Cream is not considered as medically necessary.