

Case Number:	CM14-0002553		
Date Assigned:	04/04/2014	Date of Injury:	03/07/2007
Decision Date:	05/27/2014	UR Denial Date:	12/26/2013
Priority:	Standard	Application Received:	01/07/2014

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 and Emergency Medicine and is licensed to practice in Florida. 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:

This patient is a 49 year-old with a date of injury of 03/07/07. A progress report associated with the request for services, dated 12/02/13, identified subjective complaints of neck pain radiating into the right hand. Objective findings included tenderness to palpation of the neck. Motor and sensory function and reflexes were normal. Range-of-motion was decreased. There was also tenderness of both shoulders. Diagnoses included bilateral shoulder impingement syndrome; lateral epicondylitis; and overuse syndrome of the upper extremities. Treatment has included NSAIDs, oral opioids, benzodiazepines and topical analgesics that the record stated provides relief of symptoms.

IMR ISSUES, DECISIONS AND RATIONALES

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

DORAL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Insomnia Treatment.

Decision rationale: Doral (Quazepam) is a benzodiazepine used for insomnia. The Medical Treatment Utilization Schedule (MTUS) does not specifically address Quazepam. The Official Disability Guidelines (ODG) states that treatment of insomnia should be through correction of underlying deficits. They further state that benzodiazepines are only recommended for short-term use due to risk of tolerance, dependence, and adverse events. The Medical Treatment Utilization Schedule (MTUS) also state that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. They further note that that they are the treatment of choice in very few conditions. In this case, there is documentation of longer-term use. Additionally, the strength, dose, and quantity of the drug were not specified. Therefore, the record lacks documentation for the medical necessity of Doral (Quazepam).

DIAZEPAM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: Diazepam (Valium) is a benzodiazepine anxiolytic. The Medical Treatment Utilization Schedule (MTUS) state that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. They further note that that they are the treatment of choice in very few conditions. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. In this case, there is documentation of longer-term use. Additionally, the strength, dose, and quantity of the drug were not specified. Therefore, the record lacks documentation for the medical necessity of diazepam (Valium).

NAPROXEN: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

Decision rationale: Naproxen is a non-steroidal anti-inflammatory agent (NSAID). NSAIDs have been recommended for use in osteoarthritis. It is noted that they are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs are also recommended as an option for short-term symptomatic relief on back pain. Again, no one NSAID was superior to another. The record indicates that the therapy is long-term rather than for a short period. Since NSAIDs are recommended for the shortest period possible, there must be documented evidence of functional improvement to extend therapy beyond that. Additionally, the strength, dose, and quantity of the drug were not specified. Therefore, the record does not document the medical necessity for naproxen.

HYDROCODONE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: Hydrocodone is classified as an opioid analgesic. The California Medical Treatment Utilization Schedule (MTUS) Guidelines related to on-going treatment of opioids state that there should be documentation and ongoing review of pain relief, functional status, appropriate 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. The documentation submitted lacked a number of the elements listed above, including the level of functional improvement afforded by the chronic opioid therapy. The patient has been on opioids well in excess of 16 weeks. In this case, though there is description of the level of pain relief, there is no documentation of the other elements of the pain assessment referenced above for necessity of therapy beyond 16 weeks, where the evidence is otherwise unclear. Additionally, the strength, dose, and quantity of the drug were not specified. Therefore, there is no documented medical necessity for hydrocodone.

FLURBIPROFEN / MENTHOL / CAPSAICIN OINTMENT: Upheld

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

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

Decision rationale: The Medical Treatment Utilization Schedule (MTUS) Chronic Pain Guidelines state that topical analgesics are recommended as an option in specific circumstances. However, they do state that they are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Flurbiprofen is an NSAID being used as a topical analgesic. The MTUS Guidelines note that the efficacy of topical NSAIDs in clinical trials has been inconsistent and most studies are small and of short duration. Recommendations primarily relate to osteoarthritis where they have been shown to be superior to placebo during the first two weeks of treatment, but either not afterward, or with diminishing effect over another two week period. The Guidelines also state that there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. They are indicated for relief of osteoarthritis pain in joints that lend themselves to treatment (ankle, elbow, foot, hand, knee, and wrist). In neuropathic pain, they are not recommended as there is no evidence to support their use. The only FDA approved topical NSAID is diclofenac. Capsaicin is an active component of chili peppers and acts as an irritant. The Guidelines for Chronic Pain

state that capsaicin topical is recommended only as an option in patients who have not responded or are intolerant to other treatments. It is noted that there are positive randomized trials with capsaicin cream in patients with osteoarthritis, fibromyalgia, and chronic non-specific low back pain, but it should be considered experimental at very high doses. The Guidelines further note that although capsaicin has moderate to poor efficacy, it may be particularly useful (alone or in combination with other modalities) in patients whose pain has not been controlled successfully with conventional therapy. In this case, there is no documentation of the failure of conventional therapy, documented functional improvement, or recommendation for all the ingredients of the compound. The Guidelines further state any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Lastly, the strength, dose, and quantity of the drug were not specified. Therefore the record does not document the medical necessity of the compounded formulation.