

Case Number:	CM14-0148930		
Date Assigned:	09/18/2014	Date of Injury:	08/22/2013
Decision Date:	10/30/2014	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	09/12/2014

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 Family Medicine and is licensed to practice in North Carolina. 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:

The patient is a 58-year-old with a reported date of injury of 08/22/2013. The patient has the diagnoses of left wrist joint effusion, left wrist TFCC tear, right wrist chondromalacia, right wrist osteoarthritis, left wrist radial styloid tenosynovitis, crush injury of left fingers, arthritis of the MTP joint, left foot bursitis and left foot joint effusions. Per the most recent progress notes provided for review by the primary treating physician dated 06/24/2014, the patient had complaints of dull achy wrist pain rated a 7/10 and sharp stabbing left foot pain rated a 5-8/10. The physical exam noted tenderness to palpation at the carpal tunnel and the first dorsal extensor muscle, the left TFC at the wrist and the interphalangeal joints bilaterally. There was decreased range of motion in the wrists, a positive Tinel's and Finkelstein's sign on the right and bilaterally positive Phalen's sign. Sensation to pinprick was diminished over the C5-T1 dermatomes bilaterally. The left foot was tender at the head of the great toe and first and second web space. The left ankle had decreased range of motion and a positive Mulder's sign. The treatment plan recommendations included continuation of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Capsaicin: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medical Treatment Guidelines, capsaicin Page(s): 28-29.

Decision rationale: The California chronic pain medical treatment guidelines section on capsaicin states: Recommended only as an option in patients who have not responded or are intolerant to other treatments. Formulations: Capsaicin is generally available as a 0.025% formulation (as a treatment for osteoarthritis) and a 0.075% formulation (primarily studied for post-herpetic neuralgia, diabetic neuropathy and post-mastectomy pain). There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. Indications: There are positive randomized studies with capsaicin cream in patients with osteoarthritis, fibromyalgia, and chronic non-specific back pain, but it should be considered experimental in very high doses. Although topical capsaicin has moderate to poor efficacy, it may be particularly useful (alone or in conjunction with other modalities) in patients whose pain has not been controlled successfully with conventional therapy. The number needed to treat in musculoskeletal conditions was 8.1. The number needed to treat for neuropathic conditions was 5.7. (Robbins, 2000) (Keitel, 2001) (Mason-BMJ, 2004) The results from this RCT support the beneficial effects of 0.025% capsaicin cream as a first-line therapy for OA pain. (Altman, 1994) Mechanism of action: Capsaicin, which is derived from chili peppers, causes vasodilation, itching, and burning when applied to the skin. These actions are attributed to binding with nociceptors, which causes a period of enhanced sensitivity followed by a refractory period of reduced sensitivity. Topical capsaicin is superior to placebo in relieving chronic neuropathic and musculoskeletal pain. Capsaicin produces highly selective regional anesthesia by causing degeneration of capsaicin-sensitive nociceptive nerve endings, which can produce significant and long lasting increases in nociceptive thresholds. (Maroon, 2006) Adverse reactions: Local adverse reactions were common (one out of three patients) but seldom serious (burning, stinging, erythema). Coughing has also been reported. See also CRPS, medications; Topical analgesics. This medication is only recommended in patients with documentation of failure or intolerance to other first-line treatment options. There is no such documentation of failure or intolerance included in the progress notes submitted for review. Therefore criteria for the use of the medication have not been met and the request not medically necessary.

Flurbiprofen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medical Treatment Guidelines, Guidelines topical analgesics Page(s): 111-112.

Decision rationale: The California chronic pain medical treatment guidelines section on topical analgesics states: Recommended as an option as indicated below. 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. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate.

(Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor. (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Non-steroidal anti-inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. (Lin, 2004) (Bjordal, 2007) (Mason, 2004) When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. In this study the effect appeared to diminish over time and it was stated that further research was required to determine if results were similar for all preparations. (Biswal, 2006) These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. (Mason, 2004) Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use. This medication has been used for greater than the 4-12 weeks recommended per the California MTUS. Therefore the request has not met criteria as set forth in the California MTUS as such, the request is considered not medically necessary.

Tramadol: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medical Treatment Guidelines, Opioids Page(s): 76-80, 93-94,124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medical Treatment Guidelines, Guidelines Opioids Page(s): 76-84.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: 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. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's"

(analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000)(d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management.(e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control.(f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion).(g) Continuing review of overall situation with regard to non-opioid means of pain control.(h) 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 does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids(a) If the patient has returned to work(b) If the patient has improved functioning and pain(Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004)The long-term use of this medication is not recommended unless certain objective outcome measures have been met as defined above. There is no provided objective outcome measure that shows significant improvement in function while on the medication. There is no evidence of failure of other conservative treatment modalities besides physical therapy and other first line choices for chronic pain. There is no included significant improvement in VAS scores. For these reasons criteria for ongoing and continued use of the medication have not been met. Therefore the request is not medically necessary.

Tabradol: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medical Treatment Guidelines Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medical Treatment Guidelines, Muscle Relaxants Page(s): 63-65.

Decision rationale: The California chronic pain medical treatment guidelines section on muscle relaxants states:Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (Van Tulder, 2003) (Van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. The long term chronic use of this medication is not recommended per the California MTUS. The medication has not been prescribed for the acute flare up of chronic low back pain. The specific use of this medication for greater than 3 weeks is not recommended per the California MTUS. The criteria set forth above for its use has not been met. Therefore the request is not medically necessary.