

<b>Case Number:</b>	CM14-0168325		
<b>Date Assigned:</b>	10/17/2014	<b>Date of Injury:</b>	06/27/2011
<b>Decision Date:</b>	12/26/2014	<b>UR Denial Date:</b>	09/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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 injured worker is a 57-year-old female, with a reported date of injury of 06/27/2011. The injured worker tripped and fell over a box, injuring her neck, right shoulder, right arm, and lumbar spine. The current diagnoses include displacement of cervical intervertebral disc without myelopathy; displacement of lumbar intervertebral disc without myelopathy; rotator cuff sprain; and thoracic sprain. The past diagnoses include complete tear of the right rotator cuff, chondromalacia, lumbosacral radiculopathy, sprain/strain of the neck, and sprain/strain of the wrist. Treatments include nerve conduction study; MRI of the right shoulder, which showed a complete tear of the rotator cuff; psychological care; physical therapy for the lumbar spine three (3) times a week for four (4) weeks; x-ray of the right shoulder and right humerus, which showed no progression of degenerative changes; x-ray of the cervical spine, which showed loss of cervical lordosis; x-rays of the thoracic and lumbar spine, which revealed loss of lumbar lordosis, diagnostic right shoulder arthroscopy with acromioplasty. The progress report (PR-2) dated 09/03/2014 indicated that the injured worker was being seen for follow-up on her right shoulder, cervical spine, and lumbar spine. The injured worker reported a lot of pain in her right groin area, and indicated that her right shoulder was always swollen. She admitted that she was doing a lot better, but was concerned about a lump in her shoulder. She rated her pain a 6 out of 10. The objective findings included anterior and posterior tenderness, and decreased strength in the internal and external rotation. The injured worker reported that she did not think that the physical therapy was helping her lumbar spine, and wanted to get an evaluation for her right hip. The treating provider has recommended an additional 12 sessions of physical therapy to regain strength, dynamic stabilization, and to help reduce the injured worker's pain to a more manageable level. During the visit, the injured worker was administered an ultrasound-guided trigger point injection to the lumbar spine, to help alleviate pain and reduce inflammation. She

was given Hydrocodone/APAP 10/325 mg #60 for pain; Orphenadrine Citrate ER 100 mg #60; Diclofenac Sodium ER 100mg #60 for inflammation and swelling; and Pantoprazole Sodium ER 20 mg #60 to prevent gastritis/heartburn. The injured worker was also given a prescription for Orphenadrine/Caffeine 50/10 mg #60; Gabapentin/Pyridoxine 250/10 mg #60, two (2) times daily; Omeprazole/Flurbiprofen 10/100 mg #60; Flurbiprofen/Cyclobenzaprine/Menthol 20/10/4% cream 180 mg for pain; Keratek Gel 4oz bottle for pain and inflammation; and Vicosetron (Hydrocodone) 10/300/2 mg #40. The injured worker was instructed to remain off work until 10/15/2014. On 09/11/2014, Utilization Review (UR) denied the request for Orphenadrine/Caffeine 50/10 mg #60, Gabapentin/Pyridoxine 250/10 mg #120, Omeprazole/Flurbiprofen 10/100 mg #60, Keratek Gel 4 oz bottle, and Flurbiprofen/Cyclobenzaprine/Menthol 20/10/4% cream 180 mg. The UR physician noted that the documentation does not show evidence of muscle spasms, radiculopathy, increased gastrointestinal (GI) risk, acute exacerbation, or failure of oral medications. The UR physician cited the MTUS guidelines.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Orphenadrine/Caffeine 50/10 mg #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66 of 127.

**Decision rationale:** Regarding the request for Orphenadrine/Caffeine, Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the medication. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested Orphenadrine/Caffeine is not medically necessary.

#### **Gabapentin/Pyridoxine 250 mg/10 mg, #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-21 of 127.

**Decision rationale:** Regarding request for Gabapentin/Pyridoxine, Chronic Pain Medical Treatment Guidelines state that antiepilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response

is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is no identification of neuropathic pain, any specific analgesic benefit (in terms of percent reduction in pain or reduction of NRS), and no documentation of specific objective functional improvement. Additionally, there is no discussion regarding side effects from this medication or a rationale for the pyridoxine component. In the absence of such documentation, the currently requested gabapentin/pyridoxine is not medically necessary.

**Omeprazole 10 mg/Fluriprofen 100 mg, #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk; NSAIDs (non-steroidal).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72 of 127.

**Decision rationale:** Regarding the request for Omeprazole, California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Regarding the Flurbiprofen component, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for omeprazole, and there is no indication that NSAIDs are providing any specific analgesic benefits (in terms of percent pain reduction or reduction in numeric rating scale) or any objective functional improvement. In the absence of such documentation, the currently requested Omeprazole/Flurbiprofen is not medically necessary.

**Keratek Gel #4 oz: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

**Decision rationale:** Regarding the request for Keratek gel, CA MTUS states that topical NSAIDs are indicated for "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." Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications

rather than the FDA-approved oral forms for this patient. In light of the above issues, the requested Keratek gel is not medically necessary.

**Flurbiprofen/Cyclo/Menth Cream 20%/10%/4% 180 gm:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

**Decision rationale:** Regarding the request for Flurbiprofen/Cyclo/Menth cream, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Topical NSAIDs are indicated for "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." Muscle relaxants are not supported by the CA MTUS for topical use. Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. In light of the above issues, the requested Flurbiprofen/Cyclo/Menth cream is not medically necessary.