

Case Number:	CM14-0215711		
Date Assigned:	02/06/2015	Date of Injury:	09/12/2003
Decision Date:	06/11/2015	UR Denial Date:	11/26/2014
Priority:	Standard	Application Received:	12/23/2014

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. 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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 58 year old female, who sustained an industrial injury on 09/12/2003. She has reported right shoulder pain. The diagnoses have included status post right shoulder surgery; and right wrist/hand carpal tunnel syndrome. Treatment to date has included medications, acupuncture, physical therapy, and surgical intervention. Medications have included Norco, Soma, Ambien, Terocin Pain Patches, Methoderm Gel, and multiple compounded creams. Currently, the injured worker complains of constant right shoulder pain, rated 10/10 on the visual analog scale; constant right wrist pain, rated 8/10 on the visual analog scale; and pain is rated 4-5/10 with medications. A progress report from the treating physician, dated 06/11/2014, documented the injured worker to have decreased right shoulder range of motion; impingement sign is positive on the right shoulder; and decreased right wrist range of motion. The treatment plan has included request for prescription medications. On 11/26/2014 Utilization Review noncertified prescriptions for Retrospective Urine drug screen 8/20/14; Soma 350 mg #90; Norco 10/325 mg #120; Terocin 120 ml; Flurbi NAP cream-LA 180 gms; Gabacyclotram 180 mgs; Genicin #90 capsules; Somnicin #30 capsules; Terocin pain patch #20; Methoderm gel 120 ml; Calypxo cream 113 gm; MRI right wrist; and MRI right shoulder; and modified a prescription for Ambien 10 mg #30, to Ambien 10 mg #10. The CA MTUS, ACOEM and the ODG were cited. On 12/15/2014, the injured worker submitted an application for IMR for review of a prescription for Retrospective Urine drug screen 8/20/14; Soma 350 mg #90; Ambien 10 mg #30; Norco 10/325 mg #120; Terocin 120 ml; Flurbi NAP cream-LA 180 gms;

Gabacyclotram 180 mgs; Genicin #90 capsules; Somnicin #30 capsules; Terocin pain patch #20; Menthoderm gel 120 ml; Calypxo cream 113 gm; MRI right wrist; and MRI right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Urine drug screen 8/20/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Urine Drug Testing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43.

Decision rationale: The request for retrospective urine drug screen 08/20/2014 is not medically necessary. According to the California MTUS Guidelines, drug testing may be recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. The injured worker was noted to be on opioid therapy; however, the documentation did not provide sufficient evidence of a suspicion of misuse or risk stratification. The injured worker was noted with prior inconsistent screens; however, the documentation did not indicate how an additional urine drug screen will change the treatment plan, as previous inconsistent screens have not modified the treatment plan with regard to ongoing use. Given the above, the request is not supported. As such, the request is not medically necessary.

Soma 350 #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Soma; Muscle Relaxants Page(s): 29.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Page(s): 65.

Decision rationale: The request for Soma 350 #90 is not medically necessary. According to the California MTUS Guidelines, Soma is recommended for no longer than a 2 to 3 week period. The documentation indicates the injured worker has been prescribed Soma since at least 09/2013. The documentation did not provide sufficient evidence of efficacy of this medication for this injured worker. In the absence of documentation with sufficient evidence of the efficacy of the medication and as guidelines do not recommend chronic use, the request is not supported. As such, the request is not medically necessary.

Ambien 10mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Zolpidem (Ambien).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and stress, Insomnia.

Decision rationale: The request for Ambien 10 mg #30 is not medically necessary. According to the Official Disability Guidelines, zolpidem by be recommended for short term treatment of insomnia. It is usually 2 to 6 weeks. This medication can be habit forming and may impair function and memory. The documentation indicates the medication has been prescribed since at least 09/2013. The documentation does not provide sufficient evidence of the efficacy of the medication for this injured worker. In the absence of documentation with sufficient evidence of the efficacy for the medication and as the guidelines do not recommend chronic use of the medication, the request is not supported. As such, the request is not medically necessary.

Norco 10/325mg #120: 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): 78.

Decision rationale: The request for Norco 10/325 mg #120 is not medically necessary. According to the California MTUS Guidelines, continued opioid therapy may be recommended for patients with ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include a current quantified pain, the least reported pain over the period since last assessment, intensity of pain after taking the opioid; and how long pain relief lasts. As well as 4 domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids including pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug related behaviors. The documentation did not provide sufficient evidence of a complete and thorough pain assessment, to include a current quantified pain. The documentation did not provide sufficient evidence of significant objective functional improvement. The documentation did not provide sufficient evidence of appropriate medication use, there was noted inconsistent urine drug screens in the documentation. Given the above, the request is not supported. As such, the request is not medically necessary.

Terocin 120ml: Upheld

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

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

Decision rationale: The request for Terocin 120 mL is not medically necessary. According to the California MTUS Guidelines, topical analgesics are largely experimental in use with few

randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants or anticonvulsants have failed. There was little to no research to support the use of any of these agents. Any compound product that contains at least 1 drug (or drug class) that is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful with the specific therapeutic goal required. The efficacy and clinical trials for nonsteroidal anti-inflammatory topical agents have 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. There are no long term studies of their effectiveness or safety. Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy. Topical lidocaine, in the formulation of a dermal patch, Lidoderm, has been designated for orphan status by the FDA for neuropathic pain. No other commercially approved topical formulations of lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. Capsaicin may be recommended only as an option in patients who have not responded or are intolerant to other treatments. The documentation did not provide sufficient evidence of a failure or intolerance to other treatments, failed first line therapy using antidepressant or anticonvulsants. The documentation did not provide sufficient evidence of the efficacy for this medication for the injured worker. Given the above, the request was not supported. As such, the request is not medically necessary.

Flurbi NAP cream- LA 180gms: Upheld

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

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

Decision rationale: The request for flurbi NAP cream - LA 180 gm is not medically necessary. According to the California MTUS Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants or anticonvulsants have failed. There was little to no research to support the use of any of these agents. Any compound product that contains at least 1 drug (or drug class) that is not recommended, is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful with the specific therapeutic goal required. The efficacy and clinical trials for nonsteroidal anti-inflammatory topical agents have 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. There are no long term studies of their effectiveness or safety. Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy. Topical lidocaine, in the formulation of a dermal patch, Lidoderm, has been designated for orphan status by the FDA for neuropathic pain. No other commercially approved topical formulations of lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. Capsaicin may be recommended only as an option in

patients who have not responded or are intolerant to other treatments. The documentation did not provide sufficient evidence of a failure or intolerance to other treatments, failed first line therapy using antidepressant or anticonvulsants. The documentation did not provide sufficient evidence of the efficacy for this medication for the injured worker. Given the above, the request was not supported. As such, the request is not medically necessary.

Gabaclosetram 180mgs: Upheld

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

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

Decision rationale: The request for gabaclosetram 180mg is not medically necessary. According to the California MTUS Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants or anticonvulsants have failed. There was little to no research to support the use of any of these agents. Any compound product that contains at least 1 drug (or drug class) that is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful with the specific therapeutic goal required. The efficacy and clinical trials for nonsteroidal anti-inflammatory topical agents have 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. There are no long term studies of their effectiveness or safety. Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy. Topical lidocaine, in the formulation of a dermal patch, Lidoderm, has been designated for orphan status by the FDA for neuropathic pain. No other commercially approved topical formulations of lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. Capsaicin may be recommended only as an option in patients who have not responded or are intolerant to other treatments. The documentation did not provide sufficient evidence of a failure or intolerance to other treatments, failed first line therapy using antidepressant or anticonvulsants. The documentation did not provide sufficient evidence of the efficacy for this medication for the injured worker. Given the above, the request was not supported. As such, the request is not medically necessary.

Genicin #90 capsules: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate) Page(s): 50.

Decision rationale: The request for Genicin #90 capsules is not medically necessary. According to the California MTUS Guidelines, glucosamine may be recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. However, the documentation did not provide sufficient evidence of a diagnosis of osteoarthritis. Given the above, the request is not supported. As such, the request is not medically necessary.

Somnicin #30 capsules: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter , Insomnia Treatment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Somnicin.

Decision rationale: The request for Somnicin #30 capsules is not medically necessary. Somnicin contains ingredients such as melatonin, 5-HTP, L-tryptophan, vitamin B6 and magnesium. According to the Official Disability Guidelines, Somnicin is not recommended. It is postulated as a treatment for insomnia, anxiety and depression. The documentation did not provide sufficient evidence of diagnosis or condition to indicate the use of this medication. Furthermore, the documentation did not provide sufficient evidence the injured worker is unable to take conventional antidepressant. Given the above, the request is not supported. As such, the request is not medically necessary.

Terocin pain patch #20: Upheld

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

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

Decision rationale: The request for Terocin pain patch #20 is not medically necessary. According to the California MTUS Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants or anticonvulsants have failed. There was little to no research to support the use of any of these agents. Any compound product that contains at least 1 drug (or drug class) that is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful with the specific therapeutic goal required. The efficacy and clinical trials for nonsteroidal anti-inflammatory topical agents have 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. There are no long term studies of their effectiveness or safety. Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy. Topical lidocaine, in the formulation of a dermal patch,

Lidoderm, has been designated for orphan status by the FDA for neuropathic pain. No other commercially approved topical formulations of lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. Capsaicin may be recommended only as an option in patients who have not responded or are intolerant to other treatments. The documentation did not provide sufficient evidence of a failure or intolerance to other treatments, failed first line therapy using antidepressant or anticonvulsants. The documentation did not provide sufficient evidence of the efficacy for this medication for the injured worker. Given the above, the request was not supported. As such, the request is not medically necessary.

Menthoderm gel 120ml: Upheld

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

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

Decision rationale: The request for Mentoderm gel 120 mL is not medically necessary. According to the California MTUS Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants or anticonvulsants have failed. There was little to no research to support the use of any of these agents. Any compound product that contains at least 1 drug (or drug class) that is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful with the specific therapeutic goal required. Capsaicin may be recommended only as an option in patients who have not responded or are intolerant to other treatments. The documentation did not provide sufficient evidence of a failure or intolerance to other treatments, failed first line therapy using antidepressant or anticonvulsants. The documentation did not provide sufficient evidence of the efficacy for this medication for the injured worker. Given the above, the request was not supported. As such, the request is not medically necessary.

Calypxo cream 113gm: Upheld

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

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

Decision rationale: The request for Calypxo cream 113 gm is not medically necessary. According to the California MTUS Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants or anticonvulsants have failed. There was little to no research to support the use of any of these agents. Any compound product that contains at least 1 drug (or drug class) that is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful

with the specific therapeutic goal required. The documentation did not provide sufficient evidence of a failure or intolerance to other treatments, failed first line therapy using antidepressant or anticonvulsants. The documentation did not provide sufficient evidence of the efficacy for this medication for the injured worker. Given the above, the request was not supported. As such, the request is not medically necessary.

MRI right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist, & Hand Chapter, MRIs (magnetic resonance imaging).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

Decision rationale: The request for MRI right wrist is not medically necessary. According to the California MTUS/ACOEM Guidelines, for most patients presenting with true hand and wrist problems, special studies are not needed until after a 4 to 6 week period of conservative care and observation. Most patients improve quickly, provided red flag conditions are ruled out. The documentation did not provide sufficient evidence of any red flags, significant subjective symptoms or objective findings suggestive of significant pathology. The documentation did not provide sufficient evidence of tried and failed conservative care. Given the above, the request is not supported. As such, the request is not medically necessary.

MRI right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-9.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: The request for MRI right shoulder is not medically necessary. According to the California MTUS/ACOEM Guidelines, for most patients with shoulders problems, special studies are not needed until after a 4 to 6 week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided red flag conditions are ruled out. The primary criteria for ordering imaging studies include emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery. The documentation did not provide sufficient evidence of red flags, objective symptoms of nerve dysfunction or damage, or evidence of a tried and failed conservative care. Given the above, the request is not supported. As such, the request is not medically necessary.