

Case Number:	CM14-0082363		
Date Assigned:	07/21/2014	Date of Injury:	04/27/2010
Decision Date:	05/14/2015	UR Denial Date:	05/08/2014
Priority:	Standard	Application Received:	06/04/2014

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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 41-year-old female who reported an injury on 04/27/2010. The mechanism of injury was not provided. Prior therapies included 24 sessions of physical therapy for the lumbar spine, cervical spine, and right shoulder. The injured worker was noted to be status post 2 surgical arthroscopic procedures. There was a Request for Authorization submitted for review dated 04/14/2014. Documentation of 04/14/2014 revealed the injured worker had complaints of neck pain rated 7/10 to 8/10, right shoulder pain of 8/10, and low back pain of 7/10. The injured worker reported anxiety and depression. The physical examination revealed decreased range of motion of the lumbar spine and palpation elicited 3+ tenderness and hypertonicity of the paralumbar muscles bilaterally. The Kemp's test was positive bilaterally. The injured worker had decreased range of motion of the right shoulder in flexion and abduction. There was a positive impingement and empty can test on the right. The diagnoses included cervical disc syndrome, status post right shoulder rotator cuff surgery x2, lumbar disc syndrome, lumbar spine sprain/strain, right shoulder tear of the supraspinatus with moderate acromioclavicular joint arthrosis per MRI, and anxiety referred to an appropriate specialist. The treatment plan included a refill of TGHOT and Flurflex creams. Additionally, the request was made for refills of cyclobenzaprine and omeprazole, as well as Norco 10/325 mg. The request was made for a pain management specialist to address epidural steroid injections to the cervical and lumbar spine. The injured worker underwent an MRI of the lumbar spine without contrast on 10/09/2013, which revealed mild degenerative changes of the lumbosacral spine. The injured worker underwent an MRI of the cervical spine without contrast on 04/17/2013, which revealed

a suggestion of mild left neural foraminal stenosis at C3-4; however, it was possible that was secondary to motion. There was no evidence of obvious abnormality on the sagittal images. There was no posterior disc bulge and no central canal stenosis. There was no evidence of central canal or neural foraminal stenosis within the other levels of the cervical spine. The injured worker underwent electrodiagnostic studies on 01/14/2013, which revealed no electrodiagnostic evidence of cervical radiculopathy, plexopathy, polyneuropathy, or myopathic process. There was right sided median motor neuropathy demyelination in nature. The recording of the median nerve was limited despite maximum stimulation and repeat evaluation was suggested when the injured worker returned for a suprascapular nerve evaluation. The plan was for a repeat bilateral median nerve NCS when the injured worker returned upon resolution of skin irritation to the shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

refill TGHOT cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol, Gabapentin, Topical Capsaicin, Topical Analgesics, Topical Salicylates, Tramadol Page(s): 82, 113, 28, 111, 105, 82. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA.gov.

Decision rationale: The California Medical Treatment Utilization Schedule indicates that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical Salicylates are recommended. A thorough search of FDA.gov, did not indicate there was a formulation of topical Tramadol that had been FDA approved. The approved form of Tramadol is for oral consumption, which is not recommended as a first line therapy. Gabapentin: Not recommended. There is no peer-reviewed literature to support use. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. 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. The clinical documentation submitted for review failed to provide documentation that the injured worker had a trial and failure of antidepressants and anticonvulsants. There was a lack of documentation indicating the injured worker had not responded or was intolerant to other treatments. There was a lack of documented efficacy for the requested medication as in an objective decrease in pain and an objective improvement in function. There was a lack of documentation exceptional factors to warrant non-adherence to guideline recommendations. The request as submitted failed to indicate the frequency, body part, and the specific quantity of TGHOT Cream being requested. Given the above, the request for refill TGHOT Cream is not medically necessary.

refill Flex topical cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flurbiprofen, Topical analgesics, Cyclobenzaprine Page(s): 72, 111, 41.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. 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. This agent is not currently FDA approved for a topical application. FDA approved routes of administration for Flurbiprofen include oral tablets and ophthalmologic solution. A search of the National Library of Medicine - National Institute of Health (NLM-NIH) database demonstrated no high quality human studies evaluating the safety and efficacy of this medication through dermal patches or topical administration. The guidelines do not recommend the topical use of Cyclobenzaprine as a topical muscle relaxant as there is no evidence for use of any other muscle relaxant as a topical product. The addition of cyclobenzaprine to other agents is not recommended. The clinical documentation submitted for review failed to provide documentation that there had been a trial and failure of antidepressants and anticonvulsants. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. There was a lack of documented efficacy for the requested medication as in an objective decrease in pain and an objective improvement in function. There was a lack of documentation indicating a necessity for both a topical and oral form of a muscle relaxant. The request as submitted failed to indicate the frequency, quantity, and body part to be treated. Given the above, the request for refill Flex topical cream is not medically necessary.

Cyclobenzaprine 7.5mg #180: Upheld

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

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

Decision rationale: The California Medical Treatment Utilization Schedule guidelines recommend muscle relaxants as a second line option for the short-term treatment of acute low back pain and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review failed to provide a necessity for both a topical and oral form of a muscle relaxant. There was a lack of documentation of objective functional benefit. The documentation indicated this was a refill, and as this medication is not recommended for longer than 3 weeks, this request would not be

supported. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for cyclobenzaprine 7.5mg #180 is not medically necessary.

Omeprazole DR 20mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend proton pump inhibitors for injured workers at intermediate risk or higher for gastrointestinal events. They are also for the treatment of dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review failed to provide the efficacy for the requested medication. There was a lack of documentation indicating the injured worker had dyspepsia. This medication was noted to be a refill. There was a lack of documentation indicating a necessity for 120 tablets for 1 month at current dosing. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for omeprazole DR 20mg #120 is not medically necessary.

Norco 10/325mg #80: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management, opioid dosing Page(s): 60, 78, 86.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend opioids for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Norco 10/325mg #80 is not medically necessary.

pain management consult: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, pain chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management Page(s): 78.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines recommend 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. The clinical documentation submitted for review indicated the injured worker was being referred to a pain management specialist to be evaluated for epidural steroid injections. However, the MRIs and electrodiagnostic studies would not support the injections. As such, this request is not supported. Given the above, the request for pain management consult is not medically necessary.