

Case Number:	CM15-0095897		
Date Assigned:	06/29/2015	Date of Injury:	03/12/2015
Decision Date:	09/10/2015	UR Denial Date:	04/30/2015
Priority:	Standard	Application Received:	05/18/2015

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

Certification(s)/Specialty: Emergency Medicine

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 51 year old female who sustained an industrial injury on 03/12/2015. Current diagnoses include rotator cuff tear of the right shoulder, lateral epicondylitis of the right elbow, carpal tunnel syndrome of the bilateral wrists and hands with early carpometacarpal joint osteoarthritis at the base of both thumbs, disc herniation of the lumbar spine at the L5-S1 level, medial meniscus tears of the bilateral knees with patellar instability, bilateral ankle instability, and plantar fasciitis and calcaneal spurring of the bilateral feet. Previous treatments included therapy. Previous diagnostic studies include x-rays. Initial injuries occurred to her musculoskeletal system secondary to repetitive work. Report dated 04/15/2015 noted that the injured worker presented with complaints that included right shoulder pain, bilateral wrist pain with numbness and tingling in the thumbs, index, and long fingers of both hands, right elbow pain and stiffness, bilateral knee pain with locking, catching, and instability, bilateral ankle pain and swelling with instability, pain in the base of the heel, and low back pain with radiation to the legs. Pain level was not included. Physical examination was positive for right shoulder tenderness, slightly decreased range of motion and decreased strength, impingement tests I and II are positive. Examination of the right elbow revealed tenderness with swelling. Bilateral hand and wrist examination revealed tenderness in the dorsal aspects, decreased grip strength, and decreased sensation in the thumbs, index, and long fingers of both hands. Examination of the thoracolumbar spine revealed tenderness and spasm, and positive straight leg raise on the right. Knee examination revealed intra-articular effusion of both knees, pain with palpation over the medial joint lines, and patella apprehension sign and patella grind test are positive bilaterally.

Bilateral foot and ankle examination revealed marked tenderness with instability. The treatment plan included obtaining MRI scans of the lumbar spine, bilateral knees, and right shoulder to further assess for pathology, obtain an EMG/NCS of the bilateral upper extremities, prescriptions for Orphenadrine/caffeine, gabapentin/pyridoxine, omeprazole/flurbiprofen, flurbiprofen/cyclo/menthol cream, Keratek gel, mometasone/doxepin, and request for a urine toxicology screening. The injured worker is temporary totally disabled. Disputed treatments include Orphenadrine 50mg/caffeine 10mg 1 cap 2-3 times per day as needed, #60, Gabapentin/Pyridoxine 250/10mg, 2 caps twice daily, #120, Omeprazole 10mg/Flurbiprofen 100mg, 1 cap 2-3 times a day #60, Keratek Gel (Methyl Salicylate/Menthol), apply 1-2 gms, 2-3 times per day, #4 oz, Flurbiprofen 20%/Cyclobenzaprine 10%/Menthol cream 4%, apply 1-2 gms, 2-3 times per day #180, Mometasone/Doxepin 0.15%/5%.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orphenadrine 50mg/caffeine 10mg 1 cap 2-3 times per day as needed, #60, prescribed 04/15/15: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chapter - Topical analgesics.

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

Decision rationale: The request is for the use of a muscle relaxant to aid in pain relief. The MTUS guidelines state that the use of a medication in this class is indicated as a second-line option for short-term treatment of acute exacerbations of low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, which can increase mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain improvement. Efficacy appears to diminish over time, and prolonged use may lead to dependence. (Homik, 2004) Due to inadequate qualifying evidence for use of a muscle relaxant, the request is not medically necessary.

Gabapentin/Pyridoxine 250/10mg, 2 caps twice daily, #120, prescribed 04/15/15: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chapter - Topical analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-17 of 127.

Decision rationale: The request is for the use of a medication in the category of an anti-epileptic drug (AED). These medications are recommended for certain types of neuropathic pain. Most of the randomized clinical control trials involved include post-herpetic neuralgia and painful

polyneuropathy such as in diabetes. There are few trials which have studied central pain or radiculopathy. The MTUS guidelines state that a good response to treatment is 50% reduction in pain. At least a 30% reduction in pain is required for ongoing use, and if this is not seen, this should trigger a change in therapy. There also should be documentation of functional improvement and side effects incurred with use. Disease states which prompt use of these medications include post-herpetic neuralgia, spinal cord injury, chronic regional pain syndrome, lumbar spinal stenosis, post-operative pain, and central pain. There is inadequate evidence to support use in non-specific axial low back pain or myofascial pain. In this case, there is inadequate documentation of a condition which would support the use of an anti-epileptic drug. The records also do not reveal functional improvement or screening measures as required. As such, the request is not medically necessary.

Omeprazole 10mg/Flurbiprofen 100mg, 1 cap 2-3 times a day #60, prescribed 04/15/15:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chapter - Topical analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68 of 127.

Decision rationale: The request is for the use of a medication in the class of a proton pump inhibitor. This is usually given as an acid reducing medication for patients with esophageal reflux, gastritis, or peptic ulcer disease. It can also be used as a preventative measure in patients taking non-steroidal anti-inflammatories for chronic pain. Unfortunately, they do have certain side effects including gastrointestinal disease. The MTUS guidelines states that patients who are classified as intermediate or high risk, should be treated prophylactically. Criteria for risk are as follows: "(1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anti-coagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)." Due to the fact the patient does not meet to above stated criteria, the request for use is not medically necessary.

Keratek Gel (Methyl Salicylate/Menthol), apply 1-2 gms, 2-3 times per day, #4 oz, prescribed 04/15/15: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chapter - Topical analgesics, Salicylate topicals.

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

Decision rationale: The request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients which each have specific properties and mechanisms of action. The MTUS guidelines state the following: "Any compounded

product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, the compounded topical treatment contains an NSAID. Qualifying factors for this product is indicated by the following per the guidelines: 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. 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. FDA-approved agents: Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. In this case, as stated above, the patient would not qualify for the use of a topical NSAID. This is based on the diagnosis and treatment duration. As such, the request is not medically necessary.

Flurbiprofen 20%/Cyclobenzaprine 10%/Menthol cream 4%, apply 1-2 gms, 2-3 times per day #180, prescribed 04/15/15: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chapter - Topical analgesics.

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

Decision rationale: The request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients which each have specific properties and mechanisms of action. The MTUS guidelines state the following: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, the use of the topical muscle relaxant is not indicated for use for the patient's condition. The MTUS states the following: "There is no evidence for use of any other muscle relaxant as a topical product." As such, the request is not medically necessary.

Mometasone/Doxepin 0.15%/5%, apply 1-2 gms, 2-3 times per day, #60gm, prescribed 04/15/15: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chapter - Topical analgesics.

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

Decision rationale: The request is for the use of topical corticosteroids to aid in pain relief. The MTUS guidelines are silent regarding this topic. As such, the ODG is referenced and state the following: Under study: Not widely used or recommended, but limited evidence exists for the effectiveness of local corticosteroid therapy in reducing plantar heel pain. Topical corticosteroid administered by iontophoresis may be more effective than injected corticosteroid. (Crawford, 2002) (Crawford-Cohrane, 2003) In this case, as indicated above, there is poor evidence regarding effectiveness with use. As such, the request is not medically necessary.