MAXIMUS Federal Services

Case Number:	CM13-0033017		
Date Assigned:	04/25/2014	Date of Injury:	08/19/2011
Decision Date:	06/12/2014	UR Denial Date:	09/30/2013
Priority:	Standard	Application Received:	10/09/2013

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 & Rehabilitation 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 patient is a 62 year old female who was injured on 08/19/2011. Mechanism of injury is unknown. Prior treatment history was not submitted in documents for review. Diagnostic studies reviewed include urine drug screen dated 05/15/2013 showing inconsistent result. Analyte detected without prescribed medication. There were positive results for Hydrocodone, Venalfaxine which were not corresponding with prescribed medication, including illicit. MRI of the lumbar spine dated 06/26/2013 revealed in L3-4 posterior annular tear seen within the intervertebral disc. There was a 2-3 mm posterior disc bulge resulting in moderate left neural foraminal narrowing in conjunction with facet joint hypertrophy. Moderate canal stenosis is seen. At L4-5 Grade I anterolisthesis is accompanied by a 2-3 mm posterior disc bulge resulting in moderate to severe bilateral neural foraminal narrowing in conjunction with facet joint hypertrophy. Moderate to severe canal stenosis is seen. PR-2 dated 05/15/2013 documented the patient with complaints of continuous low back pain and depression. Pain level awakens her at night and causes her to take medication. Patient further reports that her legs feel like they are going numb. Patient states she cannot sleep at night due to pain and stress. Objective findings on examination of low back reveal decreased range of motion upon flexion, extension, right/left rotation and right/left lateral bending bilaterally of the lower back region, secondary to left leg pain. Treatment Plan includes Zanaflex and Norco to reduce pain. Pending physical therapy 6 visits and pending orthopedic consultation of the lumbar spine. PR-2 dated 07/10/2013 documented the patient with complaints of pain in the lumbar region. Her pain level has remained the same. There were no objective findings submitted with this visit. Diagnoses are Lumbar disc disorder and Lumbar radiculopathy. Plan included referral to specialist. UR dated 09/30/2013 denied the request for Hydrocodone/APAP 10/325 mg #120 (A modified approval of the originally requested quantity of #120), Tizanidine HCL #90 for 30 days, Terocin Lotion

2.5%/25%, Flurbiprofen cream and Gabacyclotram cream due to the fact that there was no documentation of any objective functional improvement or pain relief with its use, it is not recommended by the Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE HYDROCODONE/APAP #120 FOR 30 DAYS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 74-94.

Decision rationale: According to the California MTUS guidelines, Hydrocodone is short acting opioid that is recommended for intermittent or breakthrough pain. The medical records document the patient was diagnosed with lumbar disc disorder, and lumbar radiculopathy. In the absence of documented exact duration and frequency of Hydrocodone intake and absence of documented significant improvement of pain and function, the request cannot be supported based on the MTUS guidelines. The retrospective request for Hydrocodone/APAP # 120 for 30 days is not medically necessary and appropriate.

RETROSPECTIVE NEW TEROCIN LOTION 2.5%/25% COMPOUND CAPSAICIN 0.025%, METHYL SALICYLATE 25%, MENTHOL 10%, AND LIDOCAINE 2.5%: 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): 111-112.

Decision rationale: According to the California MTUS guidelines, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Lidocaine as a dermal patch is recommended for neuropathic pain. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The medical records document the patient was diagnosed with lumbar disc disorder, and lumbar radiculopathy. As the medication includes one compound that is not recommended according to the guidelines, the request cannot be supported. Therefore, the retrospective request for New Terocin Lotion 2.5%/25% Compound Capsaicin 0.025%, Methyl Salicylate 25%, Menthol 10%, and Lidocaine 2.5%, is not medically necessary and appropriate.

RETROSPECTIVE FLURBIPROFEN (NAP) CREAM, COMPOUND FLURBIPROFEN, LIDODERM, AND AMITRYPTYLINE: 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: According to the California MTUS guidelines, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Amitriptyline as a topical form is not recommended. There is no peer-reviewed literature to support use of topical use. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The medical records document the patient was diagnosed with lumbar disc disorder, and lumbar radiculopathy. As the medication includes one compound that is not recommended according to the guidelines, the request cannot be supported. Therefore, the retrospective request for Flurbiprofen (NAP) Cream, Compound Flurbiprofen, Lidoderm, and Amitryptyline, is not medically necessary and appropriate.

RETROSPECTIVE GABACYCLOTRAM CREAM, COMPOUND GABAPENTIN, CYCLOBENZAPRINE, AND TRAMADOL: 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: According to the CA MTUS guidelines, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Gabapentin as a topical form is not recommended. There is no peer-reviewed literature to support use of topical use. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The medical records document the patient was diagnosed with lumbar disc disorder, and lumbar radiculopathy. As the medication includes one compound that is not recommended according to the guidelines, the request cannot be supported. The retrospective request for Gabacyclotram Cream, Compound Gabapentin, Cyclobenzaprine, and Tramadol is not medically necessary and appropriate.

RETROSPECTIVE TIZANIDINE HCL #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS (FOR PAIN) Page(s): 66.

Decision rationale: According to the California MTUS guidelines, Tizanidine is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. The medical records document the patient was diagnosed with lumbar disc disorder, and lumbar radiculopathy. In the absence of documented exact duration and frequency of the medication intake, and absence of documented significant improvement of pain and function, the request cannot be supported. The retrospective request for Tizanidine HCL #90 is not medically necessary and appropriate.