

Case Number:	CM13-0048271		
Date Assigned:	12/27/2013	Date of Injury:	06/30/2006
Decision Date:	05/22/2014	UR Denial Date:	10/22/2013
Priority:	Standard	Application Received:	11/05/2013

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 and Rehabilitation and is licensed to practice in Texas and Oklahoma. 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 50-year-old male who reported an injury on 06/30/2006. The mechanism of injury was not provided for review. The injured worker was evaluated in 06/2013. It was documented that the injured worker's medications included Norco, Zanaflex, and Prilosec. It was noted at that time that the injured worker has gastritis and the use of Prilosec did minimize the injured worker's gastritis. The injured worker was again evaluated on 10/10/2013. It was documented that the injured worker's medications continued to include Norco, Prilosec, and Zanaflex. It was documented that the injured worker had 8/10 pain that was reduced with medications. Continued use of medications with the addition of Terocin patches was recommended. The injured worker was again evaluated on 12/05/2013. The injured worker's medications at that time included Norco 10/325 mg daily for severe pain, Prilosec, Norflex as needed for muscle spasming, and Terocin patches. It was noted that the injured worker's medications decreased his pain by 50% and allowed him to increase his walking distance by approximately 20 minutes. Physical findings included tenderness to palpation of the lower lumbar facets bilaterally, and limited range of motion secondary to pain. The injured worker's diagnoses included lumbar facet pain syndrome, degenerative disc disease of the lumbar spine with radiculopathy and facet arthropathy, bilateral wrist complaints, status post left inguinal hernia repair, status post bilateral carpal tunnel releases and left knee pain. The injured worker's treatment plan included continuation of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

OMEPRAZOLE 20MG CAPSULES #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-68.

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

Decision rationale: The requested Omeprazole 20 mg capsules #60 are not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of gastrointestinal protectants be supported by evaluation of the injured worker's risk factors to determine the need for a gastrointestinal protectant. The clinical documentation submitted for review does not provide a recent assessment of the injured worker's gastrointestinal system to allow for determination of ongoing use of this medication. The last documentation of gastritis was in 06/2013. Therefore, the continued need of this medication is not supported. Also, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Omeprazole 20 mg capsules #60 are not medically necessary or appropriate.

ORPHENADRINE CITRATE 100MG ER #60: Upheld

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

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

Decision rationale: The requested Orphenadrine citrate 100 mg ER #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not support the use of muscle relaxants in the management of chronic pain. The California Medical Treatment Utilization Schedule recommends muscle relaxants for short durations of treatment not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. The clinical documentation submitted for review does indicate that the injured worker has been on this medication for an extended duration. Therefore, continued use of this medication would not be supported. Additionally, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Orphenadrine citrate 100 mg ER #60 is not medically necessary or appropriate.

TEROCIN PATCH BOX (10 PATCHES/BOX): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

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

Decision rationale: The requested Terocin patch box, 10 patches in each box, is not medically necessary or appropriate. The requested medication is a compounded medication that contains Methyl Salicylate, Menthol, and Capsaicin. California Medical Treatment Utilization Schedule does recommend the use of menthol and methyl salicylate in topical applications for the management of osteoarthritic pain. However, the use of capsaicin should be reserved for injured workers who have failed other first-line chronic pain management treatments. The clinical documentation does not provide any evidence that the injured worker has not responded to first-line medications to include anticonvulsants and antidepressants. Therefore, the use of a medication with topical capsaicin is not supported. Additionally, the request as it is submitted does not provide a frequency of treatment or body part. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Terocin patch box, 10 patches per box, is not medically necessary or appropriate.

HYDROCODONE/APAP 10/325MG #135: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 87-91.

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

Decision rationale: The requested Hydrocodone/APAP 10/325 mg #135 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documentation of functional benefit, evidence of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the injured worker has 50% pain relief and an increase in an ability to walk for approximately 20 minutes as a result of medication usage. However, the clinical documentation submitted for review does not provide any evidence that the injured worker is monitored for aberrant behavior. Therefore, continued use of this medication would not be supported. As such, the requested Hydrocodone/APAP 10/325 mg #135 is not medically necessary or appropriate.