

Case Number:	CM13-0049715		
Date Assigned:	12/27/2013	Date of Injury:	04/17/2013
Decision Date:	06/04/2014	UR Denial Date:	10/24/2013
Priority:	Standard	Application Received:	11/08/2013

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 Orthopedic Surgery has a subspecialty in Spine Surgery and is licensed to practice in Texas. 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 38 year old male injured on 04/17/13 when he was struck in the back during an assault, fell to the ground catching himself with his right arm. Current diagnoses include rotator cuff sprain, lateral epicondylitis, and osteoarthritis of the hand. It does not appear that the patient has undergone surgical intervention for his injuries to date; however, has participated in physical therapy and medication management. EMG/NCV of the lower extremities performed on 08/05/13 was found to be normal. MRI of the cervical spine performed on 08/02/13 revealed overall very mild multi-level discogenic/degenerative changes without central canal stenosis identified throughout with mild multi-level foraminal narrowing. MRI of the lumbar spine revealed mild multi-level discogenic changes, mild acquired central stenosis at L3-4 and borderline acquired central stenosis at L2-3 with no foraminal narrowing identified. The clinical note dated 11/20/13 indicates the patient continued to complain of severe pain in the back and arms. The patient reports pain is worsening and now radiating into extremities causing weakness and discomfort. Physical examination reveals decreased motion, sensation, and strength to the lumbar spine. The patient rates his pain at 7/10. The documentation indicates thoracic spine and lumbar spine x-rays revealed loss of lumbar lordosis. The patient received trigger point injections at the time of that visit and was recommended to continue physical therapy and multiple medications. The patient was provided Hydrocodone/Acetaminophen 10/325mg, Cyclobenzaprine 7.5mg, Diclofenac Sodium ER 100mg, Pantoprazole Sodium ER 20mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

A URINE DRUG SCREEN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES: PAIN CHAPTER, URINE DRUG TESTING (UDT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOID Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, clinicians may consider the use of a urine drug screen to assess for the use or the presence of illegal drugs. However, with the denial of the requested opioid medication, there is no requirement for further urine drug screening. As such, the request for A URINE DRUG SCREEN is not recommended as medically necessary.

BIOTHERM GEL 120MG: Upheld

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

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

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, CA MTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Therefore for BIOTHERM GEL 120MG cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

THERAFLEX 180MG: Upheld

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

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

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, CA MTUS, Food and Drug

Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Therefore THERAFLEX 180MG cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

DYOTIN SR 250MG #120: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GABAPENTIN (NEURONTIN®), PAGE 49.

Decision rationale: As noted on page 49 of the Chronic Pain Medical Treatment Guidelines, Gabapentin is a first-line choice for the treatment of neuropathic pain. The clinical documentation indicates objective findings consistent with neuropathy. As such, the request for DYOTIN SR 250MG #120 is recommended as medically necessary.

HYDROCODONE/APAP 10/325MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation ODG TWC 2013, PAIN.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. In addition, no recent opioid risk assessments regarding possible dependence or diversion were available for review. Moreover, there were no recent urine drug screen reports made available for review. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of HYDROCODONE/APAP 10/325MG #60 cannot be established at this time.

CYCLOBENZAPRINE 7.5MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS (FOR PAIN).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CYCLOBENZAPRINE Page(s): 41.

Decision rationale: As noted on page 41 of the Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine is recommended as a second-line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Studies have shown that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. It appears the patient has exceeded the 2-4 week window for acute management and also indicates a lack of efficacy if being utilized for chronic flare-ups. Additionally, there is no subsequent documentation regarding the benefits associated with the use of cyclobenzaprine following initiation. As such, the medical necessity of CYCLOBENZAPRINE 7.5MG #60 cannot be established at this time.

DICLOFENAC ER 100MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS, AND CARDIOVASCULAR RISK.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, SPECIFIC DRUG LIST & ADVERSE EFFECTS Page(s): 70.

Decision rationale: As noted on page 70 of the Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended as a second-line treatment after acetaminophen for acute exacerbations of chronic pain. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute lower back pain. Package inserts for NSAIDs recommend periodic lab monitoring of a CBC and chemistry profile (including liver and renal function tests). There is no documentation that these monitoring recommendations have been performed and the patient is being monitored on a routine basis. Additionally, it is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time. As such, the request for DICLOFENAC ER 100MG #60 cannot be established as medically necessary.

PANTOPRAZOLE ER 20MG #60: 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, PROTON PUMP INHIBITORS, (PPIs).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN CHAPTER, PROTON PUMP INHIBITORS, (PPIs).

Decision rationale: As noted in the Official Disability Guidelines - Online version, Pain Chapter, proton pump inhibitors are indicated for patients at intermediate and high risk for gastrointestinal events with concurrent use of non-steroidal anti-inflammatory drug use. Risk factors for gastrointestinal events include age > 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). There is no indication that the patient is

at risk for gastrointestinal events requiring the use of proton pump inhibitors. Furthermore, long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture. As such, the request for PANTOPRAZOLE ER 20MG #60 cannot be established as medically necessary.

EMG/NCV FOR THE UPPER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178, 261, 303, 309.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

Decision rationale: As noted in the Hand, Wrist and Forearm Disorders chapter of the American College of Occupational and Environmental Medicine, electrodiagnostic studies are recommended to evaluate non-specific hand, wrist, or forearm pain for patients with paresthesias or other neurological symptoms. The clinical note dated 11/20/13 indicates the patient continued to complain of severe pain in the back and arms. The patient reports pain is worsening and now radiating into extremities causing weakness and discomfort. The objective findings were vague and did not specify the level of parathesia, etc. As such, the request for EMG/NCV FOR THE UPPER EXTREMITIES cannot be recommended as medically necessary.

EMG/NCV OF THE LOWER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178, 261, 303, 309.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: As noted in the Low Back Disorders chapter of the American College of Occupational and Environmental Medicine, electrodiagnostic studies are not recommended for patients with acute, subacute, or chronic back pain who do not have significant lower extremity pain or numbness. The documentation indicates the patient had normal electrodiagnostic studies of the lower extremities performed on 08/05/13. As such, the request for EMG/NCV OF THE LOWER EXTREMITIES cannot be recommended as medically necessary at this time.