

Case Number:	CM13-0053086		
Date Assigned:	12/30/2013	Date of Injury:	03/11/2006
Decision Date:	07/31/2014	UR Denial Date:	11/05/2013
Priority:	Standard	Application Received:	11/18/2013

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 Family Medicine and is licensed to practice in Arizona. 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 58-year-old male, with a date of injury on 3/11/2006. The diagnoses include cervical discogenic disease, cervical spine sprain, lumbar discogenic disease, chronic low back pain, right knee internal derangement, hypertension, and recent possible left sided stroke. The subjective complaints are of persistent low back pain rated 7-8/10, and right knee pain with popping and snapping. A physical exam shows cervical spine tenderness, and pain with range of motion. The lumbar spine shows weakly positive straight leg raise test, with lumbar tenderness. The right knee has medial and lateral joint line tenderness, and patellofemoral crepitation with range of motions. The medications include Terocin, Norco, colace, Restoril, Prilosec, and Anaprox.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anaprox DS #60, with no refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68.

Decision rationale: The Chronic Pain Guidelines recommend non-steroidal anti-inflammatory drugs (NSAIDs) at the lowest effective dose in patients with moderate to severe pain. Furthermore, NSAIDs are recommended as an option for short-term symptomatic relief for back pain. For this patient, moderate pain is present in multiple anatomical locations, including the back. Chronic NSAIDs are not recommended for patients with hypertension. This patient has hypertension and recent stroke-like symptoms. Therefore, the use of Anaprox is not medically necessary.

Prilosec 20mg #60, with no refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The Chronic Pain Guidelines indicate that a proton pump inhibitor (PPI) can be added to non-steroidal anti-inflammatory (NSAID) therapy if the patient is at an intermediate to high risk for adverse gastrointestinal (GI) events. The guidelines identify the following as risk factors for GI events: age >65, history of peptic ulcer, GI bleeding or perforation, use of aspirin (ASA), corticosteroids, anticoagulant use, or high dose NSAIDs. The Official Disability Guidelines suggest that proton pump inhibitors (PPIs) are highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. This patient is not recommended to be on NSAID therapy, and has no evidence of ongoing gastric complaints. Therefore, the medical necessity of omeprazole is not established.

Restoril 20mg # 30, with no refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Insomnia treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Insomnia treatment.

Decision rationale: The Chronic Pain Guidelines do not recommend anxiolytics as first line therapy for stress-related conditions as they can lead to dependence and do not alter stressors or the individual's coping mechanisms. Benzodiazepines in particular are not recommended for long-term use, because long-term efficacy is unproven. Most guidelines limit use to four (4) weeks, due to dependence and tolerance that can occur within weeks. The Official Disability Guidelines indicate that benzodiazepines for insomnia are only recommended for short-term use due to risk of tolerance, dependence, and adverse events. Therefore, the medical necessity of Restoril is not established.

Terocin lotion #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

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

Decision rationale: Terocin is a compounded medication that includes methyl salicylate, menthol, lidocaine, and capsaicin. The Chronic Pain Guidelines are clear that if the medication contains one (1) drug that is not recommended the entire product should not be recommended. Topical lidocaine in the form of Lidoderm may be recommended for localized peripheral pain. No other commercially approved topical formulations of lidocaine are indicated. While capsaicin has some positive results in treating osteoarthritis, fibromyalgia and non-specific back pain, it has shown moderate to poor efficacy. Topical Salicylates have been demonstrated as superior to placebo for chronic pain to joints amenable to topical treatment. The menthol component of this medication has no specific guidelines or recommendations for its indication or effectiveness. In addition to capsaicin and menthol not being supported for use in this patient's pain, the medical records do not indicate the anatomical area for it to be applied. Due to Terocin not being in compliance to current use guidelines the requested prescription is not medically necessary.

Transcutaneous electrical nerve stimulation (TENS) unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114-121.

Decision rationale: The Chronic Pain Guidelines indicate that the criteria for transcutaneous electrical nerve stimulation (TENS) use include: chronic pain longer than three (3) months, evidence that conservative methods and medications have failed, and a one month trial of TENS use with appropriate documentation of pain relief and function. For this patient, the request is for a TENS unit. The medical record does not identify a one (1) month trial of this treatment modality. Due to lack of documentation regarding previous trial, a TENS unit for purchase is not medically necessary.