

Case Number:	CM13-0058693		
Date Assigned:	12/30/2013	Date of Injury:	10/18/2010
Decision Date:	04/10/2014	UR Denial Date:	11/13/2013
Priority:	Standard	Application Received:	11/27/2013

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 Anesthesiology and Pain Medicine, and is licensed to practice in Florida. 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 31-year-old who reported an injury on 11/18/2010. The mechanism of injury was noted to be the patient was hit in the back of her right ankle causing her to roll the right foot/ankle. The patient's medication history as of 2012 included tramadol, Neurontin, Cymbalta, and Zofran. The patient's medications as of 04/2013 included Meloxicam, Terocin, Percocet, Cymbalta, Neurontin, tramadol, Allegra, Astelin, vitamin D, and Zofran. The recent documentation of 10/03/2013 revealed that the patient's pain score was a 7/10. The functional impairment was noted to be severe, interfering with most but not all daily activities, and the need for pain medication was noted to have no change. The patient's ability to sleep was noted to be worse. The effectiveness of the medication was noted to be unchanged in the day or night. The patient was noted to be in the office for medication refills. The patient's diagnoses were noted to include lumbosacral spondylosis with facet syndrome, reflex sympathetic dystrophy of the lower limb, and pain in the joint, ankle, foot.

IMR ISSUES, DECISIONS AND RATIONALES

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

MELOXICAM 7.5 MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67.

Decision rationale: The Chronic Pain Medical Treatment Guidelines indicate that NSAIDS (non-steroidal anti-inflammatory drugs) are recommended for short term symptomatic relief. There should be documentation of an objective functional improvement and objective decrease in the VAS (visual analog scale) score. The clinical documentation submitted for review failed to provide documentation of objective functional improvement and an objective decrease in the VAS score. The patient indicated their pain was unchanged. The need for pain medication was unchanged and their functional impairment was severe and interfered with most, but not all, daily activities. The patient was noted to be on the medication for greater than 6 months in duration. The clinical documentation submitted for review indicated the patient had been on this medication since 2012. The patient had significant functional impairment and the need for pain medication was noted to have no change. The effectiveness of the medication was noted to be unchanged in the day or night. The request as submitted failed to indicate a quantity of medication being requested. The request for Meloxicam 7.5 mg, one tablet by mouth twice perday as needed, is not medically necessary or appropriate.

TEROCIN 2.5%/0.25%/10%/25% LOTION: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 105,111, 28,.

Decision rationale: The Chronic Pain Medical Treatment Guidelines indicates that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety... are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed...Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended...Capsaicin: Recommended only as an option in patients who have not responded or are intolerant to other treatments...Lidocaine... Lidoderm...No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The Chronic Pain Medical Treatment Guidelines recommend treatment with topical salicylates. According to the website Drugs.com, Terocin is a topical analgesic containing capsaicin / lidocaine / menthol / methyl salicylate. The clinical documentation submitted for review indicated the patient had been on the medication for greater than 6 months. The request as submitted failed to indicate the quantity of medication being requested. Additionally, there was a lack of documentation indicating the patient had trialed and failed antidepressants and anticonvulsants, and had not responded or was intolerant to other treatments. The clinical documentation submitted for review indicated the patient had been on this medication since 2012. The patient had significant functional impairment and the need for pain medication was noted to have no change. The effectiveness of the medication was noted to be unchanged in the day or night. The request for Terocin 2.5%/0.25%/10%/25% lotion, applied two to three times per day as needed is not medically necessary or appropriate.

PERCOCET 5/325 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60, 78.

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommends opiates for chronic pain. There should be documentation of an objective improvement in function, objective decrease in the VAS (visual analog scale) score, and evidence that the patient is being monitored for aberrant drug behavior and side effects. Additionally, the patient was noted to be on the medication for greater than 6 months. There was a lack of documentation for the submitted request for the quantity of medication being requested. The clinical documentation submitted for review indicated the patient had been on this medication since 2012. The patient had significant functional impairment and the need for pain medication was noted to have no change. The effectiveness of the medication was noted to be unchanged in the day or night. The request for Percocet 5/325 mg, one tablet daily as needed for pain, is not medically necessary or appropriate.

TRAMADOL HCL 50 MG TABLETS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60, 78.

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommends opiates for chronic pain. There should be documentation of an objective improvement in function, objective decrease in the VAS score, and evidence that the patient is being monitored for aberrant drug behavior and side effects. There was a lack of documentation of the above recommendations. The clinical documentation submitted for review indicated the patient had been on this medication since 2012. The patient had significant functional impairment and the need for pain medication was noted to have no change. The effectiveness of the medication was noted to be unchanged in the day or night. The request as submitted failed to indicate the quantity of medication being requested. The request for Tramadol HCL 50 mg tablets, one to two by mouth three times daily as needed, is not medically necessary or appropriate.