

Case Number:	CM13-0060831		
Date Assigned:	12/30/2013	Date of Injury:	12/31/2009
Decision Date:	05/16/2014	UR Denial Date:	10/29/2013
Priority:	Standard	Application Received:	12/02/2013

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 year old female with a date of injury on December 31, 2009. Diagnoses include C3-C7 bilateral moderate to severe foraminal narrowing, left upper extremity radiculopathy, bilateral carpal tunnel syndrome, left trigger thumb, cervical facet syndrome, and depression/anxiety. The patient has ongoing symptoms related to her neck and left upper extremity. Subjective complaints are of neck, left shoulder, and left upper extremity pain rated at 6/10. A physical exam shows that the patient is in mild distress and is anxious. Her cervical spine had decreased range of motion, and had tender cervical paraspinal muscles. Medications include Ultram ER 150mg daily, Naproxen 550mg twice a day, Klonopin 1m bid as needed, Pantoprazole 20mg daily, topical terocin, cyclobenzaprine twice a day, Vicodin 5-500 twice a day, and Ambien 10mg at bedtime. The patient had declined injections for the left shoulder and cervical spine and was advised to continue home exercise program. The patient has also undergone a functional restoration program. An updated urine drug screening is present in the records as well as indications of pain relief and improvement with medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE CYCLOBENZAPRINE 7.5MG TWICE A DAY, AS NEEDED,:

Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: The California MTUS guidelines indicate that the use of cyclobenzaprine should be used as a short-term therapy, and the effects of treatment are modest and may cause adverse affects. This patient had been using muscle relaxers since onset of injury, which is longer than the recommended course of therapy of 2-3 weeks. Furthermore, muscle relaxers in general show no benefit beyond NSAIDS in pain reduction of which the patient was already taking. There is no evidence in the documentation that shows evidence of muscle spasm or that the patient experienced improvement with the ongoing use of cyclobenzaprine. Due to clear guidelines suggesting cyclobenzaprine as short-term therapy and no clear benefit from adding this medication the requested prescription for cyclobenzaprine is not medically necessary.

RETROSPECTIVE VICODIN 5/500MG TWICE A DAY,: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen, Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Page(s): 74-96.

Decision rationale: The Chronic Pain Medical Treatment Guidelines have specific recommendations for the ongoing management of opioid therapy. Clear evidence should be presented about the degree of analgesia, level of activity of daily living, adverse side effects, or aberrant drug taking behavior. The patient has been on chronic opioid therapy. The documentation shows stability on medication, an increase in functional ability, and no adverse side effects. Furthermore, documentation is presence of the California MTUS opioid compliance guidelines, including updated urine drug screen, and ongoing efficacy of medication. Therefore, the use of this medication is consistent with guidelines and is medically necessary.

RETROSPECTIVE AMBEIN 10MG EVERY NIGHT AT BEDTIME,: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Insomnia Treatment.

Decision rationale: The Official Disability Guidelines suggests that Zolpidem (Ambien) is only approved for the short-term treatment of insomnia. The recommended period for usage is usually 2 to 6 weeks and long-term use is rarely recommended. For this patient, Zolpidem has been used on a chronic basis. Sleeping pills can be habit-forming, impair function and memory, and increase pain and depression over long-term use. Therefore, continuation of this medication exceeds recommended usage per guidelines, and is not a medical necessity.

RETROSPECTIVE TOPICAL TEROCIN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 105, 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Lidoderm, Page(s): 111-113, 56.

Decision rationale: Terocin is a compounded medication that includes methyl salicylate, menthol, lidocaine, and capsaicin. The California MTUS Guidelines state that if the medication contains one 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 overall. 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.