

Case Number:	CM14-0001474		
Date Assigned:	01/22/2014	Date of Injury:	01/15/2002
Decision Date:	04/30/2014	UR Denial Date:	12/18/2013
Priority:	Standard	Application Received:	01/03/2014

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 Occupational Medicine, and is licensed to practice in California. 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 an employee of [REDACTED] and has submitted a claim for low back pain with an industrial injury date of January 15, 2002. Treatment to date has included home exercises and medications including Cymbalta, Medi-Derm/L with lidocaine topical pain relief cream q12 hours, Xanax 0.5 mg qhs prn for anxiety and stress, Lortab 10/325 mg BID for severe pain, and Prilosec 20 mg BID for stomach protection. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of low back pain, 6/10, which was primarily on the right side and aggravated by cold weather. The pain was controlled with medications for about six hours. On physical examination, examination of the cervical spine revealed slight tenderness at the cervical paravertebrals with normal range of motion but with pain at the extreme range of flexion and extension. There was no evidence of radiating pain to Final Determination Letter for IMR Case Number [REDACTED] the upper extremities. Cervical compression and Spurling tests were negative. Examination of the lumbar spine showed tenderness and spasm at the L4-5 as well as bilateral posterior superior iliac spine. There was slight limitation of extension and pain during range of motion. Straight leg raise test caused hamstring tightness and low back pain. The patient's gait was slight antalgic but did not use any assistive device. Heel and toe ambulation was painful. Examination of the right hip showed positive Patrick maneuver on the right side and has pain on internal and external rotation and extreme flexion. Neurologic examination of the lower extremities showed intact sensation.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE CONTAINER OF MEDI-DERM/L WITH LIDOCIANE TOPICAL PAIN RELIEF CREAM 30MG: Upheld

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

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

Decision rationale: The documentation submitted with this review identified Medi-Derm/L topical pain relief cream to be a compounded medication that includes capsaicin 0.035%, lidocaine 2%, menthol 5%, and methyl salicylate 0.20%. According to pages 111-113 of the MTUS Chronic Pain Guidelines, lidocaine (in creams, lotions, or gels) and capsaicin are not recommended for topical applications and there is little to no research to support the use of many agents. The MTUS Chronic Pain Guidelines only support transdermal patches for lidocaine. The MTUS Chronic Pain Guidelines only supports capsaicin when all other conventional treatments fail. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended. In this case, there was no clear rationale for using this medication as opposed to supported alternatives. Therefore, the request is not medically necessary and appropriate.

30 TABLETS OF XANAX 0.5MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines section on Benzodiazepines Page(s): 24.

Decision rationale: According to page 24 of the MTUS Chronic Pain Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. In this case, the duration of benzodiazepine use was not clear. The records also did not document continued functional benefit, a lack of adverse side effects, or aberrant behavior. Therefore, the request is not medically necessary and appropriate.

60 TABLETS OF LORTAB 10/325MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines section on Opioids Page(s): 79-81.

Decision rationale: According to pages 79-81 of the MTUS Chronic Pain Guidelines, ongoing opioid treatment is not supported unless prescriptions are from a single practitioner and are taken

as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In this case, given the 2002 date of injury, the duration of opiate use to date is not clear. In addition, there is no discussion regarding non-opiate means of pain control or endpoints of treatment. The records do not clearly reflect continued analgesia, continued functional benefit, a lack of adverse effects, or aberrant behavior. Although opiates may be appropriate, additional information would be necessary, as the MTUS Chronic Pain Guidelines require clear and concise documentation for ongoing management. Therefore, the request is not medically necessary and appropriate.

60 CAPSULES OF PRILOSEC 20MG:

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

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

Decision rationale: According to page 68 of the MTUS Chronic Pain Guidelines, proton pump inhibitors are supported in the treatment of patients with GI disorders such as gastric/ duodenal ulcers, GERD, erosive esophagitis, or patients utilizing chronic NSAID therapy. In this case, there remains no report of gastrointestinal complaints from the patient and the duration of NSAID use is not established. Therefore, the request is not medically necessary and appropriate.