

Case Number:	CM14-0005420		
Date Assigned:	01/24/2014	Date of Injury:	01/19/1996
Decision Date:	06/27/2014	UR Denial Date:	01/02/2014
Priority:	Standard	Application Received:	01/13/2014

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 a 53-year-old male who has filed a claim for chronic tendinitis of the tibialis anterior tendon and left hip trochanteric bursitis associated with an industrial injury date of January 19, 1996. Review of progress notes reports improvement of pain symptoms from the previous injection. Patient reports exacerbation of pain along the tibialis anterior tendon. Patient wears an ankle foot orthosis because of weak dorsiflexion. Findings include tenderness over the lateral aspect of the left hip in the region of the trochanteric bursa, slight decreased strength upon induction, and a markedly antalgic gait. With regards to her left ankle, there is tenderness and swelling along the tibialis anterior tendon with weak dorsi flexion. MRI of the left ankle dated June 12, 2013 showed severe tendinosis of the tibialis anterior tendon with associated inflammatory changes. There is a probable split tear of the peroneus brevis tendon. MRI of the left hip from December 2013 showed minimal synovitis of the left greater trochanteric bursa without significant intrabursal fluid, and focal tear of the anterior/superior acetabular labrum with a small para-labral cyst. Treatment to date has included NSAIDs, muscle relaxants, opioids, sedatives, Zofran, Enbrel, Lidoderm patches, Flector patches, physical therapy, bracing, injections to the left hip and tibialis anterior tendon, left tibialis anterior tendon surgeries. Patient is a candidate for intrathecal pump trial. Utilization review from January 02, 2014 denied the request for Amrix 15mg #30 as this medication is not recommended for long-term use, and Bioclusive patches as it is not clear why these are being used. Reasons for denial of Lidoderm 5% patch #60, Zofran 8mg #90, and serum drug screen were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

AMRIX 15MG A PO QD QUANTITY:30: 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 Muscle Relaxants Page(s): 63-66.

Decision rationale: As stated in CA MTUS Chronic Pain Medical Treatment Guidelines pages 63-66, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain (LBP). They may be effective in reducing pain and muscle tension, and increasing mobility. However, they show no benefit beyond NSAIDs in pain and overall improvement. Patient has been on this medication since at least January 2013. This medication is not recommended for long-term use. Therefore, the request for Amrix 15mg #30 was not medically necessary.

TOPICAL LIDODERM 5% PATCH 1 12H ON 12H OFF QUANTITY:60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56-57.

Decision rationale: As stated on pages 56-57 in the CA MTUS Chronic Pain Medical Treatment Guidelines, Lidoderm may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy. Patient has been on this medication since at least January 2013. There is no documentation regarding failure of first-line therapy in this patient. Therefore, the request for Lidoderm 5% patch was not medically necessary.

TOPICAL BIOCLUSIVE PATCH 1 TO SKIN OVER DURAGESIC Q72 QUANTITY:10
-: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Bioclusive transparent dressing by Johnson & Johnson.
<http://www.vitalitymedical.com/johnson-and-johnson-bioclusive-transparent-dressing.html>

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the product site was used instead. An online search indicates that the Bioclusive transparent dressing is used for general wound care, skin biopsies, donor sites, superficial partial

thickness burns, surgical incisions, and securing IVs and central venous catheters. In this case, there is no clear rationale for this request. There is no published literature concerning improved efficacy when using an occlusive dressing over a Duragesic patch. Therefore, the request for Bioclusive patch was not medically necessary.

ZOFRAN 8MG 1 PO TID PM N/V QUANTITY:90: Upheld

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

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, Antiemetics (for opioid nausea)

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, Ondansetron is recommended for nausea and vomiting secondary to chemotherapy, radiation, and post-operative use. Acute use is FDA-approved for gastroenteritis. It is not recommended for nausea and vomiting secondary to chronic opioid use. Patient has been on this medication since at least January 2013 for chronic nausea. However, this medication is not indicated for opioid-induced nausea. In addition, recent progress notes do not document nausea in this patient. Therefore, the request for Zofran 8mg #90 was not medically necessary.

LABORATORY TEST SERUM DRUG SCREEN QUANTITY:1: 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 Page(s): 78.

Decision rationale: As stated in page 78 of the California MTUS Chronic Pain Medical Treatment Guidelines, urine drug screens are recommended as an option to assess order use or presence of illegal drugs and as ongoing management for continued opioid use. There is no discussion regarding serum drug screens. There is no clear indication as to why a serum drug screen instead of a urine drug screen is being requested in this patient. Recent progress notes do not document patient's current medication regimen. Therefore, the request for serum drug screen was not medically necessary.