

Case Number:	CM14-0006609		
Date Assigned:	02/07/2014	Date of Injury:	06/09/2006
Decision Date:	08/11/2014	UR Denial Date:	12/17/2013
Priority:	Standard	Application Received:	01/17/2014

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 45-year-old male with a 6/9/06 date of injury. The patient stated that he sustained a specific industrial injury while trying to move a water fountain with the help of a co-worker. He stated that when he tried lifting the fountain, he felt electricity from his neck that radiated down his legs. He also felt his neck cramp and tense, and the sensation radiated all the way down. According to a report dated 11/14/13, the patient reported that the medications have helped in reducing his emotional symptoms. Without these medications, the patient's depression, anxiety, and sleep problems would worsen. At present, the plan would be to review the patient's medications with medication management sessions every 3 months. Diagnostic impression: psychological factors affecting a general medical condition, brachial neuritis, cervicgia, headaches, lumbosacral neuritis, depressive disorder. Treatment to date: medication management, activity modification, lumbar blocks, psychotherapy. In a UR decision dated 12/17/13 denied the requests for Atarax, Fioricet, and Terocin lotion.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHARMACY PURCHASE OF ATARAX 256 MG #30: 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 Other Medical Treatment Guideline or Medical Evidence: FDA (Atarax).

Decision rationale: The FDA states that Atarax is indicated for symptomatic relief of anxiety and tension associated with psychoneurosis and as an adjunct in organic disease states in which anxiety is manifested; and is useful in the management of pruritus due to allergic conditions such as chronic urticaria and atopic and contact dermatoses, and in histamine-mediated pruritus. The effectiveness of hydroxyzine as an anti anxiety agent for long term use, that is more than 4 months, has not been assessed by systematic clinical studies. In this case, there is no documentation in the reports reviewed as to whether this is a new prescription or if it is a continuous prescription. If it is a continuous prescription it is not known how long the patient has been taking this medication. A specific rationale identifying why this Atarax is indicated for this patient was not provided. Furthermore, Atarax tablets do not come in 256 mg. The available strengths are 10 mg, 25 mg, 50 mg, and 100 mg tablets. Therefore, the request for pharmacy purchase of Atarax 256 mg #30 is not medically necessary and appropriate.

FLORICET #60: 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 9792.24.2 Page(s): 23. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA (Fioricet).

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines state that barbiturate-containing analgesics are not recommended for chronic pain, with high potential for drug dependence and no evidence to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents. The FDA states that Fiorinal is indicated for the relief of the symptom complex of tension (or muscle contraction) headache. In this case, the patient is documented to have headaches; however the type of headache is not specified. There is no documentation that the patient has tried other medications for his headache. There is no rationale documented as to why Fioricet would be required in this patient despite lack of guideline support. Therefore, the request for Floricet #60 is not medically necessary and appropriate.

TEROCIN LOTION 240 MG #1: Upheld

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

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

Decision rationale: An online search revealed that Terocin is a Topical Pain Relief Lotion containing Methyl Salicylate 25%, Capsaicin 0.025%, Menthol 10%, and Lidocaine 2.50%. CA

MTUS Chronic Pain Medical Treatment Guidelines do not recommend compound medications including lidocaine (in creams, lotion or gels), for topical applications. In addition, CA MTUS states that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. While guidelines would support a capsaicin formulation, the above compounded topical medication is not recommended. Lidocaine in a topical lotion form is not recommended because the dose is not easily controlled and continued use can lead to systemic toxicity. A specific rationale identifying why Terocin would be required in this patient despite lack of guidelines support was not identified.

THREE (3) MEDICATION MANAGEMENT SESSIONS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 127,156. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

Decision rationale: The California MTUS states that consultations are recommended, and a health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present or when the plan or course of care may benefit from additional expertise. Guidelines support the referral of a patient to a specialist for evaluation when the primary treating physician deems it necessary. A UR decision dated 12/17/13 modified the request for 3 medication management sessions to 1 session. A specific rationale identifying why the patient needs 3 sessions was not provided. Therefore, the request for three (3) medication management sessions is not medically necessary and appropriate.