MAXIMUS Federal Services

Case Number:	CM14-0106763		
Date Assigned:	07/30/2014	Date of Injury:	02/26/2002
Decision Date:	10/14/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	07/09/2014

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 Anesthesiology, has a subspecialty in, 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 injured worker is a 59 year old male who reported an injury on 02/26/2002. The mechanism of injury was not provided. The injured worker had diagnoses of low back pain, degenerative disc disease, facet disease, disc protrusion, herniated disc, spinal stenosis, and foraminal stenosis. The past treatment included medications. Diagnostic testing included a magnetic resonance imaging (MRI) without contrast of the lumbar spine on 02/26/2014. The surgical history was not provided. The injured worker complained of ongoing intermittent low back pain with bending, twisting, lifting, and squatting on 05/22/2014. The physical examination revealed generalized tenderness and spasm of the lumbosacral spine. The range of motion was limited to about 70 percent of normal in all directions. Medications included anaprox 550mg, Norco 10/325mg, and Terocin patch. The treatment plan was for Norco 10/325mg #120, Terocin Patch #30, Anaproxen 550mg/tab;#120. The rationale for the request was not submitted. The request for authorization form was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines- Opioid Page(s): 78-80.

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

Decision rationale: The request for Norco 10/325mg #120 is not medically necessary. The injured worker complained of ongoing intermittent low back pain, with bending, twisting, lifting, and squatting on 05/22/2014. The California Medical Treatment Utilization Schedule (MTUS) guidelines recommend ongoing review with documentation of pain relief, functional status, appropriate medication use, and side effects. A complete pain assessment should be documented which includes current pain, the least reported pain over the period since last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The guidelines also recommend providers assess for side effects and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. The documentation submitted for review indicates that Norco is helping the patient. However, there is no quantified information regarding pain relief. There is a lack of documentation regarding consistent with urine drug screens. In addition, there is no mention of side effects. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. Given the above, the request for ongoing use of Norco is not supported. Therefore, the request for Norco 10/325 #120 is not medically necessary.

Terocin Patch #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 67-68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-112.

Decision rationale: The request for Terocin Patch #30 is not medically necessary. The injured worker complained of ongoing intermittent low back pain, with bending, twisting, lifting, and squatting on 05/22/2014. Terocin patch is comprised of Lidocaine and Menthol. The California Medical Treatment Utilization Schedule (MTUS) guidelines state, any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. The guidelines recommend the use of Lidocaine for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Topical Lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. No other commercially approved topical formulations of Lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. There is a lack of documentation indicating the injured worker has been treated with first line therapy. There is no indication that the injured worker has a diagnosis of post-herpetic neuralgia. There is no documentation indicating the provider's rationale which demonstrates why the injured worker would require a topical patch versus oral medication. The guidelines note Lidocaine in patch form, in the formulation of Lidoderm has been designated for orphan status by the FDA. Therefore, the use of Lidocaine in patch form, in combination with menthol, would not be indicated. Additionally, the request does not indicate the frequency at

which the medication is prescribed and the site at which it is to be applied in order to determine the necessity of the medication. Given the above the request for Terocin patches is not medically necessary.

Anaproxen 550mg/tab;#120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's (non-steroidal anti-inflammatory drugs) Page(s): 67-72.

Decision rationale: The request for Anaproxen 550mg/tab; #120, is not medically necessary. The injured worker complained of ongoing intermittent low back pain, with bending, twisting, lifting, and squatting on 05/22/2014. The California Medical Treatment Utilization Schedule (MTUS) guidelines recommend the use of non-steroidal anti-inflammatory drugs (NSAIDs) for patients with osteoarthritis (including knee and hip) and patients with acute exacerbations of chronic low back pain. The guidelines recommended NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. In patients with acute exacerbations of chronic low back pain, the guidelines recommend NSAIDs as an option for short-term symptomatic relief. There is a lack of documentation indicating the injured worker has been diagnosed with osteoarthritis. There is a lack of documentation of a measured assessment of the injured worker's pain level. The requesting physician's rationale for the request is not indicated within the provided documentation. Additionally, the request does not indicate the frequency at which the medication is prescribed and the site at which it is to be applied in order to determine the necessity of the medication Therefore the request for Anaproxen 550mg/tab;#120 is not medically necessary.