

Case Number:	CM14-0018413		
Date Assigned:	04/18/2014	Date of Injury:	06/25/2012
Decision Date:	07/24/2014	UR Denial Date:	01/28/2014
Priority:	Standard	Application Received:	02/13/2014

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 Anesthesiology, has a subspecialty in Pain Management 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:

This is a 41-year-old male with a June 25, 2012 date of injury, when he slipped on a slippery area at a warehouse, falling into his back. An October 1, 2013 Report by [REDACTED] identified lower back pain with tingling to both legs, as well as neck and right wrist pain. There was tenderness and spasm over the lumbar and cervical region. Treatment plan included oral meds, topical compound, acupuncture, urine analysis (UA) toxicology, and to finish shockwave treatments. A November 12, 2013 medical report by [REDACTED] identifies requests for medications including Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclophene, and Ketoprofen cream. The report states that periodic UA shall be performed. A January 4, 2014 qualified medical evaluation (QME) identified a decreased cervical range of motion with spasms. There was decreased sensation in the dorsal first webspace of the right hand. There was tenderness of the triangular fibrocartilage complex (TFCC). Lumbar range of motion was decreased. A January 28, 2014 determination was non-certified. Prilosec was not certified due to no indication of any side effects from medication management or a diagnoses of GI reflux disease. Norco was non-certified due to no functional improvement and pain reduction with the use of the medication. Naproxen was non-certified given insufficient evidence for the use of NSAIDs in the treatment of chronic musculoskeletal complaints. Cyclobenzaprine was not approved given no recent acute musculoskeletal injury or recent exacerbation of chronic complaints. The compound cream was denied given no indication that the patient had failed or was intolerant to any of the compounds in their oral form. Exoten-C lotion was denied given no recent assessments indicated that the patient had failed all other treatments for neuropathic pain. The prior report also indicated that the most recent report available for their review was from June 2013 from [REDACTED]

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION FOR PRILOSEC 20MG: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (online version), Pain Chapter, Proton Pump Inhibitors (PPIs).

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, Proton Pump Inhibitors; as well as the FDA.

Decision rationale: The Official Disability Guidelines and the FDA support proton pump inhibitors in the treatment of patients with GI disorders such as gastric/duodenal ulcers, GERD, erosive esophagitis, or patients utilizing chronic NSAID therapy. The prior determination did not have recent medical reports available. These were now provided for review and those indicate that the patient was under chronic NSAID therapy for which a PPI is indicated as GI protectant. The medical necessity for this medication was substantiated. Therefore, the request is medically necessary.

PRESCRIPTION FOR NORCO 10/325MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79-81. Decision based on Non-MTUS Citation Opioid Therapy for Chronic Pain Jane C. Ballantyne, M.D., and Jianren Mao, M.D., Ph.D (americanpainsociety.org).

Decision rationale: The records do not clearly reflect continued analgesia, continued functional benefit, a lack of adverse side effects, or aberrant behavior. It is not clear if the patient's prescriptions are coming from a single provider (given medications requests from [REDACTED] and [REDACTED]). There were also no urine drug tests, risk assessment profile, attempts at weaning/tapering, and an updated and signed pain contract between the provider and claimant, with evidence of ongoing efficacy including measurable subjective and/or functional benefit with prior use. Although opiates may be appropriate, additional information would be necessary, as the Chronic Pain Medical Treatment Guidelines require clear and concise documentation for ongoing management. Therefore, the request is not medically necessary.

PRESCRIPTION FOR NAPROXEN 550MG: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

Decision rationale: The Chronic Pain Medical Treatment Guidelines states that NSAIDs are effective, although they can cause gastrointestinal irritation or ulceration or, less commonly, renal or allergic problems. The patient has continued pain in multiple body parts for which an anti-inflammatory might be of benefit. Given that additional medications were found not medically necessary, the continuation of a NSAID is appropriate. Therefore, the request is medical necessity.

PRESCRIPTION FOR CYCLOBENZAPRINE 7.5MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63.

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain (LBP), however, in most LBP cases; they show no benefit beyond NSAIDs in pain and overall improvement. There were several medical reports that identify muscle spasms. It was also noted that the patient had been on this medication for a period of time. There was no indication of acute spasms with an intent to prescribe this medication for a short period of time. There was no clear indication of a specific benefit from this medication. The medical necessity was not substantiated. Therefore, the request is not medically necessary.

Prescription for Compounded Cyclobenzaprine (3%), Ketoprofen (20%), and Lidocaine HCL (6/15%) Ultracream (#2): Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in a 0.0375% formulation, baclofen and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. There was no indication for the prescription of compound medications as opposed to FDA approved medications. There was no indication for the need of the requested compound medications. Therefore, the request is not medically necessary.

PRESCRIPTION FOR EXOTEN-C LOTION: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Capsaicin topical and Topical Analgesics Page(s): 28-29, 111-113. Decision based on Non-MTUS Citation website dailymed.nlm.nih.gov.

Decision rationale: A search of online resources revealed that Exoten-C lotion contains methyl salicylate, menthol, capsaicin. The Chronic Pain Medical Treatment Guidelines states that capsaicin is only recommended on as a 0.025% formulation (as a treatment for osteoarthritis) and a 0.075% formulation (primarily studied for post-herpetic neuralgia, diabetic neuropathy and post-mastectomy pain). In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. There was no clear indication for the prescription of this medication. No rationale was clearly provided and there were no documented benefits from such. The medical necessity was not substantiated. Therefore, the request is not medically necessary.