

Case Number:	CM14-0125745		
Date Assigned:	08/13/2014	Date of Injury:	07/17/2010
Decision Date:	09/22/2014	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	08/08/2014

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:

This 50 year old patient had a date of injury on 7/17/2010. The mechanism of injury was not noted. In a progress noted dated 6/9/2014, subjective findings included constant neck pain radiating to lower extremities with numbness and tingling. 7/10 constant back pain, 6/10 low back pain radiating to lower extremities, 8/10 numbness and tingling. On a physical exam dated 6/9/2014, objective findings included cervical range of motion; flexion 35, extension 0. Patient uses four point walker to ambulate. Diagnostic impression shows cervical radiculopathy, thoracic sprain/strain, lumbar spine radiculopathy/Treatment to date: medication therapy, behavioral modification. A UR decision dated 7/30/2014 denied the request for Gabapentin 600mg #120, stating long term efficacy is unproven. Alprazolam 1mg #60 was denied stating long term use is not supported. Norco 5/325#160 was denied, stating there was no benefit from this drug from the reports viewed. Methylprednisolone 4mg #6 was denied stating guidelines do not indicate use of steroids in treatment of chronic pain and there is no indication of a flare up. MS contin 30mg #120 was denied stating no functional benefit from this medication. Terocin pain patch #20 was denied stating multiple components in this product area not supported, Methoderm gel #240 was denied stating it contains same formulation as Ben Gay. The rationale for the denial of Xolindol 2% cream was not located in the reports viewed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 600 mg #120: Overturned

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 Gabapentin Page(s): 16-18,18. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA Neurontin.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines states that Gabapentin has been shown to be effective for the treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. In the progress report dated 6/9/2014, the patient is noted to experience numbness and tingling to the lower extremities and back, symptoms consistent with neuropathic pain. Therefore, the request for Gabapentin 600mg #120 is medically necessary.

Alprazolam 1 mg #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 Page(s): 24.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that benzodiazepines range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. They 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. From the reports viewed, it was unclear how long the patient was on this medication, and a UDS dated 6/23/2014 shows inconsistency with the prescribed medication. Therefore, the request for alprazolam 1mg #60 is not medically necessary.

Norco 5/325 mg #160: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment 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 the reports viewed, there was no objective functional improvement noted with the analgesic regimen. Furthermore, there was inconsistency with the urine drug screen for hydrocodone performed on 6/23/2014. Therefore, the request for norco 5/325 #160 is not medically necessary.

Methylprednisolone 4 mg #6: 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: methylprednisolone.

Decision rationale: MTUS and ODG do not apply. Methylprednisolone is used to treat many different inflammatory conditions such as arthritis, lupus, psoriasis, ulcerative colitis, allergic disorders, gland (endocrine) disorders, and conditions that affect the skin, eyes, lungs, stomach, nervous system, or blood cells. In a progress report dated 6/9/2014, there was no subjective or objective evidence of swelling or an acute flare up that would necessitate the use of this medication. Therefore, the request for methylprednisolone 4mg #6 is not medically necessary.

MS Contin 30mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment 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 the notes reviewed, there was no objective functional improvement noted with the patient's opioid regimen. Furthermore, a 6/23/2014 urine drug screen showed inconsistency with the prescription for morphine. Therefore, the request for MS contin 30mg #120 is not medically necessary.

Terocin pain patch #20: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA: Terocin.

Decision rationale: MTUS chronic pain medical treatment guidelines states that topical lidocaine in the formulation of a dermal patch has been designated for orphan status by the FDA for neuropathic pain. In addition, CA MTUS states that topical lidocaine may be recommended

for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). In the reports viewed, there was no discussion of the patient failing a 1st line oral medication such as motrin or Gabapentin. Furthermore, the patient is also noted to be on menthoderm gel and Xolido 2% cream, with no discussion as the necessity of all 3. Therefore, the request for Terocin patch #20 is not medically necessary.

Menthoderm gel #240: 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): 105,111-113.

Decision rationale: CA MTUS states that topical salicylates are significantly better than placebo in chronic pain. However, while the guidelines referenced support the topical use of mental salicylates, the requested Menthoderm has the same formulation of over-the-counter products such as BenGay. It has not been established that there is any necessity for this specific brand name. It is recommended that the Menthoderm topical be modified to allow for an over-the-counter formulation. In the reports viewed, there was no discussion regarding why this patient could not utilize over the counter formulations such as BenGay. Furthermore, there was no discussion of the patient failing a 1st line oral analgesic medication such as motrin or naproxen. Therefore, the request for Menthoderm gel #240 was not medically necessary.

Xolindol 2% cream: 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: FDA:Xolido.

Decision rationale: MTUS and ODG do not address. FDA state that Xolido contains lidocaine hydrochloride 2% and is used for pain and itching and minor skin irritations due to minor cuts and scrapes. In the reports viewed, the patient is already receiving menthoderm gel as well as terocin patches, with no discussion as to why this patient would require this additional topical medication. Therefore, the request for Xolindol 2% cream is not medically necessary.