

Case Number:	CM14-0131790		
Date Assigned:	08/20/2014	Date of Injury:	02/12/2002
Decision Date:	10/01/2014	UR Denial Date:	08/06/2014
Priority:	Standard	Application Received:	08/18/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 53-year-old female who reported an injury on 02/12/2002. The mechanism of injury was not submitted for review. The injured worker has diagnoses of: lumbar disc displacement without myelopathy, ankle and tarsus enthesopathy, lumbar disc disorder with myelopathy, thoracic or lumbosacral neuritis or radiculitis not otherwise specified, disorder of coccyx not otherwise specified, lumbago, pain in the thoracic spine, sprain/strain of the lumbar region, sprain/strain of the thoracic region, and sprain/strain of the neck. Past medical treatment consists of injections, transforaminal nerve root blocks, a home exercise program, physical therapy and medication therapy. Medications consists of Relafen, Prilosec, tramadol, Ambien, Norflex, Cidaflex, Terocin patches. There were no urinalyses or drug screens submitted for review. On 07/09/2014 the injured worker complained of lower back pain. Physical examination revealed the injured worker had spasm, tenderness and guarding in the paravertebral muscles of the lumbar spine along with decreased range of motion. The treatment plan is for the injured worker to continue the use of her medications and also start the use of a lumbar corset for back support. The provider is requesting it so the injured worker could use on a daily basis for intermittent lifting and to avoid further aggravation of her industrial injuries and allow her to ambulate more functionally. The Request for Authorization was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prilosec 20mg #90 Refills: 5: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Prilosec GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The request for Prilosec 20mg #90 Refills: 5 is not medically necessary. The California MTUS Chronic Pain Guidelines that proton pump inhibitors may be recommended to treat dyspepsia, secondary to NSAID therapy. The addition of a proton pump inhibitor is also supported for patients taking NSAID medications who have cardiovascular disease or significant risk factors for gastrointestinal events. The submitted report lacked any evidence that the injured worker was taking any NSAIDs. Furthermore, there was no documentation indicating that the injured worker had complaints of dyspepsia with the use of medications, cardiovascular disease or significant risk factors for gastrointestinal events. In the absence of this documentation, the request is not supported by the evidence based guidelines. Additionally, the request as submitted failed to indicate a duration or frequency of the medication. As such, the request for Prilosec 20mg #90 Refills: 5 is not medically necessary.

Cidaflex 500/400mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines chondroitin (Cidaflex) Glucosamine (and Chondroitin Sulfate Page(s): 50.

Decision rationale: The request for Cidaflex 500/400mg #90 is not medically necessary. The California MTUS Guidelines recommend Condrolite as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. Studies have demonstrated the highly significant efficacy for crystalline, glucosamine sulfate (GS) on all outcomes, including joint space narrowing, pain, mobility, safety and response to treatment, but similar studies are lacking for glucosamine hydrochloride. In a recent meta-analysis, the authors found that the apparent benefits of side effects were largely confined to studies of poor methodological quality, such as those with small patient numbers or ones with unclear concealment of allocation. Despite multiple controlled clinical trials of glucosamine in osteoarthritis (mainly of the knee), controversy on efficacy related to symptomatic improvement study continues. Glucosamine is not recommended for low back pain. Guidelines state that glucosamine is not significantly different from placebo for reducing pain related disability or improving health related quality of life in patients with chronic low back pain and degenerative lumbar osteoarthritis. Given the above, the injured worker is not within the MTUS guidelines. In the submitted report, the injured worker complained of low back pain. However, guidelines stipulate that the use of Cidaflex is mostly used for the treatment of osteoarthritis of the knee. As such, the request for Cidaflex 500/400mg #90 is not medically necessary.

Terocin patch: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine (Terocin) Page(s): 112.

Decision rationale: The request for Terocin patches is not medically necessary. Terocin patches consist of lidocaine 4% and menthol 4%. California MTUS states lidocaine in a transdermal application is recommended for neuropathic pain and recommended for localized peripheral pain after there has been evidence of a trial of first line therapy such as a tricyclic or SNRI antidepressant or an AED such as gabapentin or Lyrica. No other commercially approved topical combinations of lidocaine or other creams, lotions or gels are indicated for neuropathic pain. Non-dermal patch formulations are generally indicated as low anesthetics and antipruritic. In February 2007 the FDA notified consumers and healthcare professionals of the potential hazards of the use of topical lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Only FDA approved products are currently recommended. The submitted report lacked documentation showing that the injured worker had a diagnosis of neuropathic pain. The guidelines also state that lidocaine is recommended for localized peripheral pain. However, there was no documentation submitted in the report that the injured worker had such pain. Furthermore, there was no evidence found in the submitted report showing the outcome of the use of first line therapy such as tricyclic or SNRI antidepressants or AED's such as gabapentin or Lyrica. Also, the efficacy of the requested medication was not documented to support continuation of the medication. The request, as submitted did not specify a duration, dosage or frequency of the medication. As such, the request for Terocin patches is not medically necessary.

Ambien 5mg #30 Refills: 5: 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, Ambien.

Decision rationale: The request for Ambien 5mg #30 Refills: 5 is not medically necessary. The Official Disability Guidelines state that zolpidem (Ambien) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually 2 to 6 weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short term benefit. While sleeping pills, so called minor tranquilizers and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long term use. They can be habit forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long term. Cognitive behavioral therapy should be an important part of an insomnia treatment plan. The request for Ambien 5 mg with a

quantity of 150 would translate to a 5 month supply of medication, and would exceed the guideline recommendation of short term use. As such, the request for Ambien 5mg #30 Refills: 5 is not medically necessary.

Norflex 100mg #60 Refills: 5: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain), (Orphenadrine) Page(s): 63-65.

Decision rationale: The request for Norflex 100mg #60 Refills: 5 is not medically necessary. According to California MTUS, orphenadrine is a non-sedating recommended muscle relaxant with caution as a second line option for short term treatment of acute exacerbations in patients with chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most low back cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also, there are no additional benefits shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Sedation is the most commonly reported adverse effect of muscle relaxant medications. Orphenadrine is similar to diphenhydramine, but has greater anticholinergic effects. The mode of action is not clearly understood. Effects are thought to be secondary to analgesic and anticholinergic properties. The request submitted did not specify the efficacy of the medication. There was no quantified information regarding pain relief. There was nothing noted in the submitted report as to whether the above medication helped the injured worker with any functional deficits. There was no assessment regarding current pain on VAS, average pain, intensity of pain, or longevity of pain relief. In addition, the request is for Norflex 100 mg with a quantity of 60 with 5 refills which is about a total of 5 months, exceeding the recommended MTUS Guidelines for short term use. Furthermore, there was no mention of any side effects. Given the above, the request for Orphenadrine is not supported by the California MTUS Guideline recommendations. As such, the request for Norflex 100mg #60 Refills: 5 is not medically necessary.

Lumbar Corset: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Lumbar supports.

Decision rationale: The request for a Lumbar Corset is not medically necessary. According to ACOEM, lumbar supports have not been shown to have any lasting benefit beyond on the acute phase of symptom relief. ODG Guidelines do not recommend the use of lumbar support for preventing neck and back pain. There is strong consistent evidence that lumbar supports were

not effective. Lumbar supports do not prevent lower back pain. A systematic review on preventing episodes of back problems found strong, consistent evidence that exercise interventions are effective and other interventions not effective, including stress management, shoe inserts, back supports, ergonomic/back education, and reduced lifting programs. This systematic review concluded that there is moderate evidence that lumbar supports are no more effective than doing nothing in preventing low back pain. Given the above, the request for lumbar corset is not recommended by ACOEM/ODG. As such, the request for a Lumbar Corset is not medically necessary.