

Case Number:	CM14-0150031		
Date Assigned:	09/18/2014	Date of Injury:	01/06/2014
Decision Date:	12/31/2014	UR Denial Date:	08/22/2014
Priority:	Standard	Application Received:	09/15/2014

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 & Rehabilitation, has a subspecialty in Pain 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 is a male patient with the date of injury of January 6, 2014. A Utilization Review dated August 19, 2014 recommended non-certification of retro Menthoderm 15/10% ointment with 3 refills, retro Terocin 4/4% topical patch dispense 10 with 2 refills, retro Anaprox/naproxen 550mg dispense 100 with 2 refills, retro Prilosec 20mg dispense 60 capsules with 2 refills, and retro Norflex. A Progress Report dated August 8, 2014 identifies Subjective Complaints of pain level 6 on a scale of 1 to 10. Objective Findings identify tender over paraspinal area bilaterally to palpation. SLR positive bilaterally. Diagnoses identify other unspecified back disorder, lumbago, thoracic or lumbosacral neuritis or radiculitis unspecified. Treatment Plan identifies continue meds.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETRO MENTHODERM 15/10% OINTMENT WITH 3 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112 of 127. Decision based on Non-MTUS Citation <http://www.physiciansproducts.net/joomla/index.php/topical-pain-creams/72-menthoderm>

Decision rationale: Regarding the request for Methoderm, this topical compound is a combination of methyl salicylate and menthol (according to the Methoderm website). Guidelines state that topical NSAIDs are recommended for short-term use. Oral NSAIDs contain significantly more guideline support, provided there are no contraindications to the use of oral NSAIDs. Within the documentation available for review, there's no indication that the patient has obtained any specific analgesic effect (in terms of percent reduction in pain, or reduced NRS) or specific objective functional improvement from the use of Methoderm. Additionally, there is no documentation that the patient would be unable to tolerate oral NSAIDs, which would be preferred, or that the Methoderm is for short term use, as recommended by guidelines. In the absence of clarity regarding those issues, the currently requested Methoderm is not medically necessary.

TEROCIN 4/4% TOPICAL PATCH DISPENSE 10 WITH 2 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 Page(s): 111-113 of 127.

Decision rationale: Regarding the request for Terocin, Terocin is a combination of methyl salicylate, menthol, lidocaine and capsaicin. Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug or drug class that is not recommended, is not recommended. Regarding the use of topical nonsteroidal anti-inflammatory, guidelines state that the efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the 1st 2 weeks of treatment osteoarthritis, but either not afterwards, or with the diminishing effect over another two-week period. Regarding use of capsaicin, guidelines state that it is recommended only as an option for patients who did not respond to or are intolerant to other treatments. Regarding the use of topical lidocaine, guidelines state that it is recommended for localized peripheral pain after there is evidence of a trial of first-line therapy. Within the documentation available for review, there is no indication that the patient is unable to tolerate oral NSAIDs. Oral NSAIDs have significantly more guideline support compared with topical NSAIDs. Additionally, there is no indication that the topical NSAID is going to be used for short duration. Additionally, there is no documentation of localized peripheral pain with evidence of failure of first-line therapy as recommended by guidelines prior to the initiation of topical lidocaine. Finally, there is no indication that the patient has been intolerant to or did not respond to other treatments prior to the initiation of capsaicin therapy. In the absence of clarity regarding those issues, the currently requested Terocin is not medically necessary.

RETRO ANAPROX/NAPROXEN 550MG DISPENSE 100 WITH 2 REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 Page(s): 67-72 of 127.

Decision rationale: Regarding the request for Naproxen, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that Naproxen is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale), or any objective functional improvement. In the absence of such documentation, the currently requested Naproxen is not medically necessary.

RETRO PRILOSEC 20MG DISPENSE 60 CAPSULES WITH 2 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS AND CARDIOVASCULAR RISKS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 Page(s): 68-69 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Proton Pump Inhibitors PPIs

Decision rationale: Regarding the request for omeprazole (Prilosec), California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. In light of the above issues, the currently requested omeprazole (Prilosec) is not medically necessary.

RETRO NORFLEX: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 Page(s): 63-66 of 127.

Decision rationale: Regarding the request for retro Norflex, Chronic Pain Medical Treatment Guidelines support the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the Norflex. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested retro Norflex is not medically necessary.