

Case Number:	CM14-0159997		
Date Assigned:	10/03/2014	Date of Injury:	05/23/1994
Decision Date:	10/30/2014	UR Denial Date:	09/22/2014
Priority:	Standard	Application Received:	09/29/2014

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 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:

The injured worker is a 61-year-old male who sustained an injury on 05/23/94. On 08/13/14, he complained of constant low back pain and left leg symptoms, rated at 5-10/10 with radiation to the left buttocks, lateral leg and dorsal foot with numbness and tingling and leg pain. Exam showed 5/5 strength in the left and right lower extremity. Lumbosacral spine exam showed moderate tenderness to palpation and limited ROM due to guarding and pain. SLR was positive on left. Walking on toes and heels is impaired. His recent MRI showed an L4-L5 disc bulge and bilateral L5 pars defects, consistent DDD & disc height loss, spondylosis, multi-factorial, multi-foraminal narrowing. He has a degenerative spondylolisthesis and pars defects at L5. Four view x-rays of the lumbar spine showed moderate spondylosis and facet arthropathy at L4-L5, L5-S1; there was a subtle spondylolisthesis at L5-S1, possibly a spondylolysis at L5-S1. He underwent a left hand surgery in 2000. Current medications include Atorvastatin Calcium, Lovaza, Aspirin EC, Terocin, Topical NSAIDs and analgesics. Past treatments have included spinal injections in 1995 and 1996 which gave temporary relief. Throughout the years he has tried physical therapy, chiropractic, acupuncture, and multiple injections with some temporary relief. Diagnoses included lumbar spondylosis, lumbar spondylolisthesis, and lumbar radiculopathy. The requests for Terocin patches 4-4% #10, 1 patch daily, Omeprazole DR 20mg #90, Topical NSAIDs and analgesic (unspecified), Physical therapy re-evaluation, Physical medicine and rehabilitation referral, and Retrospective 8/13/14 x-ray, lumbosacral spine (4 view) were denied on 09/22/2014 due to lack of medical necessity guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Terocin patches 4-4% #10, 1 patch daily: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation [http://www.odg-twc.com/odgtwc/pain.htm#Topical analgesics](http://www.odg-twc.com/odgtwc/pain.htm#Topical%20analgesics)

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

Decision rationale: According to the references, Terocin patches contain lidocaine and menthol. The California MTUS guidelines state only Lidocaine in the formulation of Lidoderm patch may be considered for localized peripheral neuropathic 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). The guidelines state no other commercially approved topical formulations of lidocaine are indicated for neuropathic pain. Only FDA-approved products are currently recommended. Topically applied lidocaine is not recommended for non-neuropathic pain. The medical records do not establish this topical patch is appropriate and medically necessary for this patient. The request of Terocin Patches is not medically necessary.

Omeprazole DR 20mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GI symptoms and cardiovascular risk.

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

Decision rationale: According to the California MTUS, Omeprazole is a PPI (proton pump inhibitor) recommended for patients at intermediate risk for gastrointestinal events. The guidelines state PPI medications such as Omeprazole (Prilosec) may be indicated for patients at risk for gastrointestinal events, which should be determined by the clinician: 1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA (aspirin), corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAIDs (non-steroidal anti-inflammatory drugs) (e.g., NSAID + low-dose ASA). Treatment of dyspepsia secondary to NSAID therapy recommendation is to stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI. The guidelines recommend GI protection for patients with specific risk factors; however, the medical records in this case do not establish that the patient is at significant risk for GI events or risks as stated above. Therefore, the medical necessity of the request is not established at this time.

Topical NSAIDs and analgesic (unspecified): 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.

Decision rationale: According to the California MTUS guidelines, topical analgesics are an option with specific indications, many agents are compounded as monotherapy or in combination for pain control. There is little to no research to support the use of many of these agents. According to the guidelines, the only NSAID that is FDA approved for topical application is Diclofenac (Voltaren 1% Gel). Clinical trial data suggest that Diclofenac sodium gel (the first topical NSAID approved in the US) provides clinically meaningful analgesia in OA patients with a low incidence of systemic adverse events. "Lidocaine" is recommended for localized peripheral neuropathic pain (i.e. post-herpetic neuralgia) 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), which is not the case here. The guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The medical necessity of this compounded topical product is not established.

Physical therapy re-evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Physical therapy. Decision based on Non-MTUS Citation Official Disability Guidelines, Preface to physical therapy

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back

Decision rationale: As per California MTUS guidelines, physical medicine is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. ODG recommends 9 visits over 8 weeks intervertebral disc disorders without myelopathy. In this case, the injury is very old and the injured worker has already received unknown number of physical therapy and chiropractic visits. However, there is no record of progress notes and there is no documentation of any significant improvement in the objective measurements (i.e. pain level, range of motion, strength or function) with prior therapy to demonstrate the effectiveness of this modality in this injured worker. There is no evidence of presentation of any new injury / surgical intervention. Moreover, additional PT visits would exceed the guidelines criteria. Furthermore, there is no mention of the patient utilizing a home exercise program (HEP). At this juncture, this patient should be well-versed in an independently applied home exercise program, with which to address residual complaints, and maintain functional levels. Therefore, the request is considered not medically necessary or appropriate in accordance with the guideline.

Physical medicine and rehabilitation referral: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, page 127

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examination & Consultation

Decision rationale: As per ACOEM guidelines, "the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise." Further guidelines indicate consultation is recommended to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. In this case, there is no mention of the reason for such referral in the medical records. Furthermore, there is no indication for any PM&R office based services such as trigger points/joint injections or EMG/NCS. As such, the request is not medically necessary due to lack of documentation.

Retrospective 8/13/14 x-ray, lumbosacral spine (4 view): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation [app-i.acoem.org/Browser/ViewRecommendation.aspxrcm=3428&text=x-rays](http://www.i.acoem.org/Browser/ViewRecommendation.aspxrcm=3428&text=x-rays)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back

Decision rationale: As per ODG guidelines, "lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management." Indications for lumbar X-ray include: lumbar spine trauma associated with pain, tenderness, neurological deficits and seat belt (Chance) fracture; uncomplicated lower back pain (LBP) associated with trauma, steroids, osteoporosis, suspicious of cancer / infection and over 70; myelopathy (painful, sudden onset, infectious disease patient and oncology patient); and post-surgical for evaluation of fusion. In this case, the above criteria were not met. Additionally, the IW had recent MRI which was diagnostic of lumbosacral degenerative spondylosis. Moreover, no specific reason had been mentioned. Therefore, the service was not medically necessary.