

Case Number:	CM14-0173735		
Date Assigned:	10/27/2014	Date of Injury:	04/09/2007
Decision Date:	12/03/2014	UR Denial Date:	10/21/2014
Priority:	Standard	Application Received:	10/21/2014

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 Orthopedic Spine Surgeon 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 60-year-old female who reported an injury on 04/09/2007 due to an unknown mechanism of injury. The diagnoses included cervical radiculopathy and lumbosacral radiculopathy. The diagnostics included an EMG/nerve conduction study dated 02/15/2013 of the bilateral upper extremities that revealed bilateral C6-7 radiculopathy. The medications included Soma, Celebrex, Enbrel, Flector patch, Neurontin, Prochlorperazine Maleate and Voltaren 1% topical gel. The injured worker complained of neck pain and dizziness. The neurological examination of the cervical spine dated 09/22/2014 revealed tenderness and decreased range of motion; reflexes with decreased pinprick, vibration, position at light touch; sensory diminished to touch at the bilateral C5, C6 and C7 distribution; normal gait and coordination; and spasm diffusely. The injured worker had limited range of motion with a flexion of 10 degrees and extension 5 degrees, lateral flexion was 10 degrees bilaterally. Reflexes were diminished at the biceps and triceps and symmetric. Surgery was recommended. The treatment plan included Prochlorperazine maleate 10 mg. The Request for Authorization dated 10/27/2014 was submitted with documentation. The rationale for the medication was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prochlorperazine Maleate 10mg tab: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter

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: RxList.com, Prochlorperazine Maleate Tablets, Indications and Dosage; <http://www.rxlist.com/prochlorperazine-maleate-tablets-drug/indications-dosage.htm>

Decision rationale: The request for Prochlorperazine Maleate 10 mg tab is not medically necessary. According to RxList.com, Prochlorperazine maleate tablets are indicated for control of severe nausea and vomiting and for the treatment of schizophrenia. Prochlorperazine Maleate is effective for the short-term treatment of generalized non-psychotic anxiety. However, Prochlorperazine is not the first drug to be used in therapy for most patients with non-psychotic anxiety, because certain risks associated with its use are not shared by common alternative treatments. The clinical notes do not indicate the usage of the medication. Prochlorperazine Maleate is recommended for antiemetic, antipsychotic, and tranquilizer, for control of severe nausea and vomiting, for the treatment of schizophrenia, or nonpsychotic anxiety. The clinical notes were not clear as to the indication of the medication. The clinical notes provided did not indicate any nausea or vomiting, or diagnosis of schizophrenia. Additionally, the request did not indicate a quantity, frequency, or duration. As such, the request is not medically necessary.

Flector 1.3% transdermal 12 hour patch: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The request for Flector 1.3% transdermal 12 hour patches is not medically necessary. The California MTUS Guidelines indicate that topical non-steroidal anti-inflammatory drugs are recommended for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. They are recommended for short-term use (4-12 weeks). Topical non-steroidal anti-inflammatory drugs are not recommended for neuropathic pain as there is no evidence to support use. The clinical notes did not indicate that the injured worker had a diagnosis of osteoarthritis. There is no indication as to the efficacy of the medication. Additionally, the request did not address the quantity, duration, or site of application of the medication. As such, the request is not medically necessary.