

Case Number:	CM14-0023662		
Date Assigned:	06/11/2014	Date of Injury:	05/16/2000
Decision Date:	08/11/2014	UR Denial Date:	01/31/2014
Priority:	Standard	Application Received:	02/25/2014

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 Texas. 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 56 year old female injured on 05/16/00 due to undisclosed mechanism of injury. Current diagnoses included lumbar segmental instability, status post right hip replacement, and internal derangement of bilateral knees. Clinical note dated 01/07/14 indicated the injured worker presented complaining of persistent low back pain radiating to lower extremities with associated numbness and tingling. The injured worker recently developed pulmonary and cardiac conditions requiring additional evaluation and treatment by the appropriate specialist. Physical examination of the lumbar spine revealed tenderness from the mid to distal lumbar segment, pain with terminal motion, positive seated nerve root test, and dysesthesia at L5 and S1 dermatomes. Physical examination of the right hip revealed tenderness at the right greater trochanteric region and pain with terminal motion and hip rotation. Evaluation of left knee revealed tenderness at left knee joint line, positive McMurray sign, positive patellar compression test, pain with terminal flexion with crepitus, and slight limp favoring the left side on ambulation. Current medication regimen was continued which was tramadol, cyclobenzaprine, and gabapentin. The initial request for omeprazole delayed release capsules 20mg #420, cyclobenzaprine HCl tablet 7.5mg #120 one tablet every eight hours as needed not to exceed more than three per day, and Terocin patch #30 was non-certified on 01/31/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

OMEPRAZOLE DELAYED RELEASE CAPSULES 20 MG, #120: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment for Worker's Compensation Pain Procedure Summary last updated 01/07/2014.

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, Proton Pump Inhibitors.

Decision rationale: As noted in the Official Disability Guidelines - Online version, Pain Chapter, proton pump inhibitors are indicated for patients at intermediate and high risk for gastrointestinal events with concurrent use of non-steroidal anti-inflammatory drug use. Risk factors for gastrointestinal events include age > 65 years; history of peptic ulcer, gastrointestinal (GI) bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). There is no indication that the injured worker is at risk for gastrointestinal events requiring the use of proton pump inhibitors (PPI). Furthermore, long-term PPI use greater than one year has been shown to increase the risk of hip fracture. As such, the request for omeprazole delayed release capsules 20 MG, #120 cannot be established as medically necessary.

CYCLOBENZAPRINE HYDROCHLORIDE TABLETS 7.5 MG, #120, ONE TABLET EVERY EIGHT HOURS AS NEEDED, NOT TO EXCEED MORE THAN THREE PER DAY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41.

Decision rationale: As noted on page 41 of the Chronic Pain Medical Treatment Guidelines, cyclobenzaprine is recommended as a second-line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Studies have shown that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Based on the clinical documentation, the injured worker has exceeded the 2-4 week window for acute management also indicating a lack of efficacy if being utilized for chronic flare-ups. As such, the medical necessity of cyclobenzaprine hydrochloride tablets 7.5 mg, #120, one tablet every eight hours as needed, not to exceed more than three per day cannot be established at this time.

TEROCIN PATCH, QUANTITY 30: 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: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. The request failed to provide a frequency of administration and number of refills limiting the ability to review the medication. As such, the request for Terocin patch, quantity 30 cannot be recommended as medically necessary.