MAXIMUS Federal Services

Case Number:	CM14-0027419		
Date Assigned:	06/13/2014	Date of Injury:	02/14/2003
Decision Date:	08/08/2014	UR Denial Date:	02/25/2014
Priority:	Standard	Application Received:	03/04/2014

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, has a subspecialty in Interventional Spine and is licensed to practice in Texas and Oklahoma. 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 68-year-old male, with a reported date of injury on 02/14/2003. The mechanism of injury was not submitted within the medical records. His diagnoses were noted to include; degenerative disc disease and cervical radiculopathy. His previous treatments were noted to include medications, physical therapy, and TENS unit. The progess note dated 08/16/2013 revealed the injured worker complained of significant increase in his neck pain and it radiated down his right upper extremity. Physical examination revealed flexion and extension was normal, right rotation was 40 degrees, and left rotation was to 30 degrees, right tilt was to 40 degrees, and left tilt was to 30 degrees. There was pain to palpation from the C4 all the way down to C7 on the right and mid spine, but negative on the left paraspinal musculature. There was pain to the right trapezius and allodynia and decreased sensitivity to the medial aspect of his right forearm. He had a positive Spurling's on the right but negative on the left. Reflexes were 1+ to the brachioradialis, triceps, and biceps on the right and on the left they are 2+ to the biceps and brachioradialis, but 1+ at the triceps. Strength was rated 4/5 to extension and flexion of the right elbow and 5/5 on the left. The injured worker's medication list was not submitted within the medical records. The Request For Authorization form dated 02/19/2014 for retrospective requests dated 08/19/2013 for Terocin patch, Motrin 800 mg #90 (date of service 04/05/2013), Zofran 8 mg #10 (date of service 06/07/2012) Keflex 500 mg #30 (date of service 06/07/2012), and Vicodin 5/500 mg #120 (date of service 08/07/2012), however the provider's rationale was not submitted within the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REVIEW OF HYDROCODONE 5/500MG #120 (DOS 8/7/2012): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 78.

Decision rationale: The retrospective review of Hydrocodone 5/500 mg #120 (DOS 08/07/2012) is non-certified. The injured worker has been utilizing this medication since at least 08/07/2012. According to the Califorina Chronic Pain Medical Treatment Guidelines, the ongoing use of opioid medications may be supported with detailed documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines also state that the 4 As for ongoing monitoring including analgesia, activities of daily living, adverse side effects, and apparent drug taking behaviors, should be addressed. There is lack of documentation regarding evidence of decreased pain on a numerical scale, improve functional status, side effects, and it is unclear whether the injured worker has had consistent urine drug screens and when the last test was performed. Therefore, due to the lack of documentation regarding significant pain relief, increased function, side effects, and without details regarding urine drug testing to verify for repeat medication use and the absence of aberrant behavior, the ongoing use of opiod medications is not supported by the guidelines. Additionally, the request failed to provide the frequency at which this medication is to be utilized. As such, the request is non-certified.

RETROSPECTIVE REVIEW OF ZOFRAN 8MG #10 (DOS 6/7/2012): 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, Anti-emetics.

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

Decision rationale: The retrospective review of Zofran 8 mg #10 (DOS 06/07/2012) is non-certified. The injured worker utilized this medication 06/07/2012. The Official Disability Guidelines do not recommend antiemetics for nausea and vomiting secondary to chronic opioid use. The guidelines state nausea and vomiting is common with the use of the opioids. This side effect tends to diminish over days to weeks of continued exposure. There is no high quality literature to support any 1 treatment for opioid-induced nausea and chronic non-malignant pain in patients. Zofran is FDA approved for nausea and vomiting seconday to chemotherapy and radiation treatment. It is also FDA approved for postoperative use and gastroenteritis. There is a lack of documentation regarding nausea and vomiting to necessitate Zofran. Additionally, the

guidelines do not recommend Zofran for nausea and vomiting, for opioid use, instead it is intended for postoperative use or gastroenteritis. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is non-certified.

RETROSPECTIVE REVIEW OF KEFLEX 500MG #30 (DOS 6/7/2012): 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Infectious Diseases, Cephalexin (Keflex).

Decision rationale: The retrospective review of Keflex 500 mg #30 (DOS 06/07/2012) is non-certified. The injured worker was prescribed Keflex 06/07/2012. The Official Disability Guidelines recommend Keflex as a first line treatment for cellulitis and other conditions. The guidelines recommend Keflex for outpatients with non-purulent celllitis, empirical treatment for infection due to beta-hemolytic streptococci and methicillin-sensitive S. aureus, as well as for penicillin allergic that can tolerate cephalosporins. There is a lack of documentation regarding an infection to necessitate Keflex. The guidelines recommend Keflex as a first line treatment for cellulitis and other conditions, and the clinical findings provided do not indicate those conditions. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is non-certified.

RETROSPECTIVE REVIEW OF MOTRIN 800MG #180 (DOS 4/5/2013): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

Decision rationale: The retrospective review of Motrin 800 mg #180 (DOS 04/05/2013) is non-certified. The injured worker was prescribed Motrin 800 mg on 04/05/2013. The California Chronic Pain Medical Treatment Guidelines recommend NSAIDS at the lowest dose with a shortest period in patients with moderate to severe pain due to osteoarthritis. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular for those with gastrioentestinal, cardiovascular or renovascular risk factors. There is no evidence of long term effectiveness for pain or function. The guidelines recommend NSAIDS as a second line treatment after acetaminophen for acute exacerbations of chronic pain. The guidelines also recommend NSAIDS as an option for short term symptomatic relief for chronic low back pain. There is a lack of documentation regarding efficacy and improved function with utilization of this medication. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, this request is non-certified.

RETROSPECTIVE REVIEW OF TEROCIN PATCH (DOS 8/19/2013): 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): 111-112.

Decision rationale: The retrospective review of Terocin patch (DOS 08/19/2013) is non-certified. The injured worker was prescribed this medication 08/19/2013 and Terocin patches consist of lidocaine and menthol. The California Chronic Pain Medical Treatment Guidelines primarily recommend topical analgesics for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The topical analgesics are largely experimental and used with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. The guidelines state that lidocaine is indicated for neuropathic pain after there has been evidence of a trial of first line therapy (tricyclic or SNRI antidepressants or NAED such as gabapentin or Lyrica). Topical lidocaine, and the formulation of a dermal patch (lidoderm) has been designated for ophan status by the FDA for neuropathic pain. No other commercially approved topical formulations have lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The guidelines do not recommend lidocaine for non-neuropathic pain and there is only one trial that tested 4% lidocaine for treatment of chronic muscle pain and the results showed there was no superiority over placebo. There is lack of documentation regarding neuropathic pain to warrant the Terocin patch. The guidelines state no other formulation other than lidoderm is indicated for neuropathic pain and Terocin is not recommended by the guidelines. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is non-certified.