

Case Number:	CM14-0034963		
Date Assigned:	06/23/2014	Date of Injury:	10/05/2011
Decision Date:	07/24/2014	UR Denial Date:	02/19/2014
Priority:	Standard	Application Received:	03/20/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Physical Medicine & Rehabilitation and Pain 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 Physician 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 45 year old female who had a work related injury on 10/05/11. Clinical documentation submitted for review, revealed no mechanism of injury documented. Injured worker had diagnosis of status post left ankle surgery 2010. There were multiple herniated discs of the lumbar spine and chondromalacia of the left knee. Treatment consisted of physical therapy, multiple visits to chiropractor, and acupuncture. She also had sacroiliac joint belts. She had medial branch block on 05/31/13 with 12 hours of almost complete relief. Awaiting authorization for radiofrequency rhizotomy. MRI of lumbar spine dated 06/03/14 L4-5 no L3-4 focal 3.3mm right posterolateral disc protrusion causing mild right neural foraminal narrowing. Spinal canal was normal in diameter and the left neural foramen was patent. Ligamentum flavum hypertrophy and facet arthrosis were noted. The descending exiting nerve roots were intact. L4-5 no posterior disc protrusion or annular bulge was identified. Spinal canal was normal in diameter and both neural foramina were patent. Articular facets and ligamentum flavum were normal in appearance. The descending exiting nerve roots were intact. L5-S1 focal 1.6 millimeter right paracentral posterior disc protrusion indenting the ventral thecal sac. Spinal canal was normal in diameter and both neural foramina were patent. Ligamentum flavum hypertrophy and facet arthrosis were noted. The descending exiting nerve roots were intact. There was an 8x2 millimeter hemangioma in the superior posterior aspect of the L3 vertebral body sacral meningeal cyst or perineural cysts were identified in the sacral spinal canal at S2 which measured approximately 1.5 centimeter. At L2-3 there was focal 3.3 millimeter left posterolateral disc protrusion narrowing the left lateral recess. Facet arthrosis contributed to mild to moderate left neural foraminal narrowing. Ligamentum flavum hypertrophy was observed. Disc material encroached upon the exiting left L2 nerve root. Most recent progress note dated 05/28/14, indicated the injured worker was in for follow up of low back pain. She

was last seen in 10/13 and had been doing very well. She was awaiting authorization for rhizotomy to the right L4-5. She last worked on 10/05/11. She was currently taking Norco 10/325 one to two times per day. Helping to decrease pain improved her ability to participate in home exercise program, such as walking. The injured worker reported her low back pain had a 6-7/10 on pain scale radiating with numbness and tingling to her bilateral lower extremities to her toes. Left side was more severe than right. Physical examination revealed tenderness to palpation to the right lower lumbar facet region. The injured worker reports pain with facet loading. Range of motion of the lumbar spine was decreased in all planes. Lower extremities sensation was intact. Strength in the right tibialis anterior and EHL rated 4+/5. Right inversion rated 5-/5. Remainder of lower extremities motor strength was intact. Straight leg raise on left at 70 degrees elicited radiation of pain down the left leg down to the calf. Straight leg raise at 60 degrees elicited radiation of pain down the right leg down to the calf. Prior utilization review dated 02/18/14 non-certification. Current request was for prospective usage of Terocin patches and hydrocodone and omeprazole and Robaxin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective usage of Terocin Patches: 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 based on Non-MTUS Citation (ODG) Pain, compound drug.

Decision rationale: The request for prospective usage of Terocin patch is not medically necessary. The current evidence based guidelines do not support the request. Terocin is a compounded agent which contains Methyl Salicylate 25%, Capsaicin 0.025%, Menthol 10%, and Lidocaine 2.5%. The California Medical Treatment Utilization Schedule, the Official Disability Guidelines and US Food and Drug Administration (FDA) do not recommend the use of compounded medications as these medications are noted to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. Further, the FDA requires that all components of a transdermal compounded medication be approved for transdermal use. This compound contains: Lidocaine which has not been approved by the Food and Drug Administration (FDA) for transdermal use. Any compounded product that contains at least one drug (or drug class) that is not recommended and therefore not medically necessary.

Prospective usage of Hydrocodone/APAP: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiate's Page(s): 74-80. Decision based on Non-MTUS Citation (ODG) Pain, opioid's.

Decision rationale: The request for prospective usage of Hydrocodone/APAP is not medically necessary. The clinical documents submitted for review do not support the request. There is no documentation of functional improvement, or UDS (urine drug screen) reports. The request does not specify the amount or the strength of Hydrocodone/APAP. As such, medical necessity has not been established.

Prospective usage of Omeprazole: 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 Workmans Compensation, Proton Pump Inhibitors (PPI's).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Pain (chronic), Proton pump inhibitors (PPIs).

Decision rationale: The request for prospective usage of Omeprazole is not medically necessary. The clinical documentation submitted for review does not support the request. There is no documentation of the injured worker having any gastrointestinal problems. The request does not specify the amount. Therefore medical necessity has not been established.

Prospective usage of Robaxin: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-67.

Decision rationale: The request for prospective usage of Robaxin is not medically necessary. The current evidence based guidelines and clinical documentation submitted for review do not support the request. The guidelines recommend non-sedating muscle relaxants with caution 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. There is no documentation of exacerbation of symptoms. The request does not specify amount of Robaxin. Therefore medical necessity has not been established.