

Case Number:	CM14-0036700		
Date Assigned:	07/25/2014	Date of Injury:	12/11/2013
Decision Date:	09/11/2014	UR Denial Date:	03/03/2014
Priority:	Standard	Application Received:	03/26/2014

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 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:

Patient is a 68-year-old male who has submitted a claim for headache, cervical radiculopathy, lumbago, thoracic / lumbosacral neuritis, shoulder tenosynovitis, carpal tunnel syndrome, post-concussion syndrome, and vision disturbance associated with an industrial injury date of 12/11/2013. Medical records from 2013 to 2014 were reviewed. Patient reported of a heavy object that suddenly dropped at the right orbital area resulting to visual disturbance and headache. Patient also complained of neck pain radiating to the trapezius, as well as dull pain over the right supraorbital and frontal regions. Patient likewise reported of pain at the left base of the skull radiating to the left shoulder and altered sensation at bilateral upper extremities. Patient also complained of low back pain. Physical examination showed tenderness and restricted range of motion of the cervical spine, lumbar spine, and bilateral shoulder. Swelling, tenderness, and ecchymosis were noted over the right superior orbit and right eyelid. Tinel's and Phalen's sign were positive. Impingement sign was also positive. Treatment to date has included physical therapy and medications. Utilization review from 03/03/2014 modified the request for Orphenadrine Citrate ER 100mg #60 x 2 refills into no refills because there was no documentation of measurable subjective or functional benefit from its use; denied Menthoderm 15%-10% Topical Ointment 120gm X 2 refills and Terocin (Lidocaine-Menthol) 4%-4% Adhesive Patch #60 x 2 refills because there was no documentation of failed trials of anticonvulsants and antidepressants; denied back brace because there was no imaging study suggesting instability, fracture, and spondylolisthesis; denied X-rays of the cervical, thoracic and lumbar spine because of no red flags or neurologic deficits in the records submitted; and denied X-ray of bilateral shoulders and bilateral wrists because there was no evidence that patient had been provided with any active skilled treatment to address shoulder complaints.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orphenadrine Citrate ER 100mg #60 x 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298. Decision based on Non-MTUS Citation Official Disability Guidelines non-sedating muscle relaxants.

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

Decision rationale: According to page 63 of the CA MTUS Chronic Pain Medical Treatment Guidelines, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain (LBP); however, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. In addition, efficacy appears to diminish over time and prolonged use of some medications in this class may lead to dependence. In this case, the patient has been on orphenadrine since December 2013. However, there was no documentation concerning pain relief and functional improvement derived from its use. Long-term use is likewise not recommended. Therefore, the request for Orphenadrine Citrate ER 100mg #60 x 2 refills is not medically necessary.

Menthoderm 15%-10% Topical Ointemnt 120gm X 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Salicylate Page(s): 105. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Section, Topical Salicylates.

Decision rationale: Page 111 of CA MTUS Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Menthoderm ointment contains methyl salicylate and menthol. Regarding the Menthol component, CA MTUS does not cite specific provisions, but the ODG Pain Chapter states that the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain menthol, or methyl salicylate, may in rare instances cause serious burns. CA MTUS states that topical salicylates (e.g., Ben-Gay, Aspercream, methyl salicylate) are significantly better than placebo in chronic pain. These products are generally used to relieve minor aches and pains. With regard to Brand name topical salicylates, these products have the same formulation as over-the-counter products such as BenGay. It has not been established that there is any necessity for a specific brand name topical salicylate compared to an over the counter formulation. Moreover, there was no documentation concerning pain relief and functional improvement derived from its use despite it being prescribed since December 2013.

Therefore, the request for Menthoderm 15%-10% Topical Ointment 120gm X 2 refills is not medically necessary.

Terocin (Lidocaine-Menthol) 4%-4% Adhesive Patch #60 x 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298,Chronic Pain Treatment Guidelines Topical analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine patch Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Section, Topical Salicylates.

Decision rationale: Terocin patch contains both lidocaine and menthol. Pages 56 to 57 of CA MTUS Chronic Pain Medical Treatment Guidelines state that topical lidocaine may be recommended for localized peripheral 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). Regarding the Menthol component, CA MTUS does not cite specific provisions, but the ODG Pain Chapter states that the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain menthol, methyl salicylate, or capsaicin, may in rare instances cause serious burns. In this case, records reviewed showed that the patient has been using Lidoderm patches since December 2013. However, there was no documentation that the patient had failure of first-line therapy. The medical necessity was not established. Therefore, the request for Terocin (Lidocaine-Menthol) 4%-4% Adhesive Patch #60 x 2 refills is not medically necessary.

Back Brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Lumbar support.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: As stated on CA MTUS ACOEM Low Back Chapter, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. In this case, the patient has been complaining of chronic back pain associated with an industrial injury date of 12/11/2013. However, the request for a back brace as part of the conservative treatment regimen is outside the initial acute phase of injury and not supported by the guidelines. There is no discussion concerning need for variance from the guidelines. Therefore, the request for back brace is not medically necessary.

X-rays of the Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182. Decision based on Non-MTUS Citation Official Disability Guidelines - criteria for X-rays.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180.

Decision rationale: As stated on pages 179-180 of the ACOEM Practice Guidelines, 2nd Edition (2004) referenced by CA MTUS, guidelines support X-ray of the cervical spine in patients with red flag conditions, physiologic evidence of tissue insult or neurologic dysfunction, or failure to progress in a strengthening program intended to avoid surgery. In this case, the patient complains of neck pain. However, there is no comprehensive physical examination available pertaining to the cervical area that may warrant further investigation by utilizing X-ray. Therefore, request for X-ray of the cervical spine is not medically necessary.

X-rays of the Thoracic Spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - criteria for X-rays.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180.

Decision rationale: As stated on pages 179-180 of the ACOEM Practice Guidelines, 2nd Edition (2004) referenced by CA MTUS, guidelines support X-ray of the thoracic spine in patients with red flag conditions, physiologic evidence of tissue insult or neurologic dysfunction, or failure to progress in a strengthening program intended to avoid surgery. In this case, the patient complains of back pain. However, there is no comprehensive physical examination available pertaining to the thoracic area that may warrant further investigation by utilizing X-ray. Therefore, request for X-ray of the thoracic spine is not medically necessary.

X-rays of the Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines - criteria for X-rays.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The CA MTUS ACOEM states that 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. In this case, the patient complains of back pain. However, there is no comprehensive physical examination available pertaining to the lumbar area that may warrant further investigation by utilizing X-ray. Therefore, the request for X-ray of the lumbar spine is not medically necessary.

X-rays of right and Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 202. Decision based on Non-MTUS Citation Official Disability Guidelines - criteria for X-rays.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207.

Decision rationale: The MTUS ACOEM guidelines state that diagnostic studies are needed when there is a new injury, red flags or a trauma. In this case, the patient complains of shoulder pain. However, there is no comprehensive physical examination available pertaining to the shoulder area that may warrant further investigation by utilizing X-ray. Therefore, the request for X-rays of the right and left shoulder is not medically necessary.

X-rays of Right and Left Wrists: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268. Decision based on Non-MTUS Citation Official Disability Guidelines - criteria for 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) Forearm, Wrist, and Hand Chapter, Radiography.

Decision rationale: The CA MTUS does not specifically address radiography of the hands and wrist. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and the Official Disability Guidelines (ODG) was used instead. According to ODG, radiography of the hands and wrist is recommended in cases of acute hand or wrist trauma and chronic wrist pain. In this case, there is no comprehensive physical examination available pertaining to the wrists that may warrant further investigation by utilizing X-ray. Therefore, the request for X-ray of the bilateral wrists is not medically necessary.