

Case Number:	CM14-0041351		
Date Assigned:	08/01/2014	Date of Injury:	06/21/2010
Decision Date:	10/29/2014	UR Denial Date:	03/24/2014
Priority:	Standard	Application Received:	04/07/2014

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 Anesthesiology and Pain Medicine and is licensed to practice in Florida. 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 52-year-old male who reported an injury on 06/21/2010, caused by an unspecified mechanism. The injured worker's treatment history included x-rays, medications, topical creams, ultrasound studies, and surgery. The injured worker was evaluated on 08/27/2014, and it is documented the injured worker complained of thoracolumbar spine, cervical spine, right shoulder, and right wrist pain. The injured worker reported hot, pinching pain to the cervical spine, mild pain to the right shoulder, and dull aching to the right wrist. With prolonged movement, pain increased. Objective findings revealed the injured worker returned with decreased motion, sensation, and loss of strength to multiple body parts. The injured worker agreed to a medical examination on 10/06/2014. The injured worker underwent x-rays of the thoracic spine and lumbar spine that revealed loss of lumbar lordosis. X-rays of the cervical spine revealed loss of cervical lordosis. X-rays of the right shoulder and right humerus revealed no increase of osteoarthritis. X-rays of the right hand and right wrist revealed no increase of osteoarthritis. Medications included tramadol, topical analgesics, and hydrocodone. Diagnoses included cervicalgia, lumbago, status post lumbar fusion, and cervical radiculopathy. The Request for Authorization was not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Theraflex Transdermal Cream 180gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain, Flurbiprofen, Topical analgesics, Cyclobenzaprine Page(s): 72, 111, 41.

Decision rationale: The request for Theraflex Transdermal Cream 180gm is not medically necessary. California MTUS indicates topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2 week period. Flurbiprofen is classified as a nonsteroidal anti-inflammatory agent. This agent is not currently FDA approved for a topical application. The FDA approved routes of administration for Flurbiprofen include oral tablets and ophthalmologic solution. A search of the National Library of Medicine - National Institute of Health (NLM-NIH) database demonstrated no high quality human studies evaluating the safety and efficacy of this medication through dermal patches or topical administration. California MTUS Guidelines do not recommend the topical use of Cyclobenzaprine as a topical muscle relaxants as there is no evidence for use of any other muscle relaxant as a topical product. The addition of cyclobenzaprine to other agents is not recommended. The provider failed to indicate the injured worker failing antidepressants and/or anticonvulsants. As such, the request for Theraflex is not medically necessary.

Keratek Gel 4oz: 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, Lidocaine Page(s): 111, 112.

Decision rationale: The CA MTUS indicates topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The California MTUS guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain." The provider failed to indicate if the injured worker had failed antidepressants and/or anticonvulsants. As such, the request for Keratek Gel 4oz is not medically necessary.

Hydrocodone/APAP 10/325mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78.

Decision rationale: The requested is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) guidelines state that criteria for use for ongoing management of opioids include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. There was no outcome measurements indicated for the injured worker such as home exercise regimen or long term functional goals for the injured worker. The request submitted failed to include duration and frequency of medication. The provider failed to include a urine drug screen for opiate compliance. As such, the request for Hydrocodone/APAP 10/325mg, #60 is not medically necessary.

Cyclobenzaprine 7.5mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41, 64.

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

Decision rationale: The requested service is not medically necessary. According California (MTUS) Chronic Pain Medical Guidelines recommends Flexeril as an option, using a short course therapy. Cyclobenzaprine (Flexeril) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. There is also a postop use. The addition of cyclobenzaprine to other agents is not recommended. Cyclobenzaprine treated patients with fibromyalgia were 3 times as likely to report overall improvement and to report moderate reductions in individual symptoms, particularly sleep. Cyclobenzaprine is closely related to the tricyclic antidepressants and amitriptyline. The documentation submitted lacked outcome measurements of conservative such as, prior physical therapy sessions and medication pain management. There was lack of documentation provided on his long term-goals of functional improvement of his home exercise regimen. In addition, the request lacked frequency and duration of the medication. As such, the request for Cyclobenzaprine 7.5mg, #60 is not medically necessary.

Diclofenac Sodium ER 100mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (non-steroidal anti-inflammatory agents) Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (Non-steroidal anti-anti-inflammatory drugs) Page(s): 67.

Decision rationale: The requested not medically necessary. The Chronic Pain Medical Treatment Guidelines recommend that Diclofenac Sodium is used as a second line treatment

after acetaminophen, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute LBP. For acute low back pain with sciatica a recent Cochrane review (included 3 heterogeneous randomized controlled trials) found no differences in treatment with NSAIDs versus. Placebo. In patients with axial low back pain this same review found that NSAIDs were not more effective than acetaminophen for acute low back pain and that acetaminophen have fewer side effects. There was lack of documentation of outcome measurements of conservative care measurements and home exercise regimen. In addition, the provider failed to indicate long-term functional goals for the injured worker. There was lack of documentation stating the efficiency of the Diclofenac Sodium for the injured worker. There was a lack of documentation regarding average pain, intensity of the pain and longevity of the pain after the Diclofenac Sodium taken by the injured worker. The request for Diclofenac Sodium did not include the frequency, quantity or duration. As such, the request for Diclofenac Sodium ER 100mg, #60 is not medically necessary.

Pantoprazole Sodium ER 20mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms & Cardiovascular Risk Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton pump inhibitors Page(s): 68-69.

Decision rationale: The requested is not medically necessary. Per California Medical Treatment Utilization Schedule (MTUS) Guidelines, Protonix/Pantoprazole Sodium is recommended for patients taking NSAIDs who are at risk of gastrointestinal events. The provider failed to submit medications for the injured worker. The documentation provided did not indicate that the injured worker was having gastrointestinal events. In addition, the request lacks the frequency of the medication for the injured worker. As such, the request for Pantoprazole Sodium ER 20mg, #60 is not medically necessary.