

Case Number:	CM14-0042833		
Date Assigned:	07/02/2014	Date of Injury:	08/26/2006
Decision Date:	08/01/2014	UR Denial Date:	03/24/2014
Priority:	Standard	Application Received:	04/09/2014

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 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:

The patient is a 61 year-old male with an 8/26/2008 date of injury. According to the 2/19/14 pain management report from [REDACTED], the patient injured his lower back from carrying heavy equipment down three (3) flights of stairs. He had been diagnosed with lumbar radiculitis; myofascial low back pain; left SI joint arthropathy; facet arthropathy; thrombocytopenia; and Hepatitis C. He had RFA x3, with some relief the first 2 times and no relief after the third. He takes Lyrica 100mg q8h; Dilaudid 4mg q6h; Ativan 2mg bid; Ambien 10mg qhs; Lidoderm patch; Celexa 40mg qd; Opana ER 10mg q12h, and Terocin cream. On 3/24/14, UR reviewed the 3/17/14 medical report and recommended against use of Ativan, Ambien, Terocin cream and the H-wave trial. The 3/24/14 medical report was not provided for this IMR.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ativan 2mg bid #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 24.

MAXIMUS guideline: Decision based on the MTUS Chronic Pain Medical Treatment Guidelines, Benzodiazepines, pg 24.

Decision rationale: The patient is a 61 year-old male with an 8/26/2008 date of injury. The 3/17/14 medical report that was provided to UR for the 3/24/14 denial was not available for this

IMR. According to the 2/19/14 pain management report from [REDACTED], the patient injured his lower back from carrying heavy equipment down three flights of stairs. He had been diagnosed with lumbar radiculitis; myofascial low back pain; left SI joint arthropathy; facet arthropathy; thrombocytopenia; and Hepatitis C. This IMR request is for necessity of Ativan 2mg bid, #60. Ativan (Lorazepam) is a benzodiazepine. MTUS guidelines for benzodiazepines states these are not recommended for long-term use and that most guidelines limit use to 4 weeks. The records show that Ativan has been used every month since at least 10/20/13. The continued use of Ativan over 5-months is not in accordance with MTUS guidelines. Recommendation is for non-certification. The request is not medically necessary and appropriate.

Ambien 10mg qhs #30: 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 Chapter; FDA (Ambien) (<http://www.drugs.com/pro/ambien.html>).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on the Non-MTUS Official Disability Guidelines (ODG) ODG-TWC guidelines, Chronic Pain Chapter, Insomnia Treatment, for Ambien, Zolpidem.

Decision rationale: The patient is a 61 year-old male with an 8/26/2008 date of injury. The 3/17/14 medical report that was provided to UR for the 3/24/14 denial was not available for this IMR. According to the 2/19/14 pain management report from [REDACTED], the patient injured his lower back from carrying heavy equipment down three flights of stairs. He had been diagnosed with lumbar radiculitis; myofascial low back pain; left SI joint arthropathy; facet arthropathy; thrombocytopenia; and Hepatitis C. This IMR request is for necessity of Ambien 10mg qhs, #30. Ambien (Zolpidem) is a short-acting nonbenzodiazepine hypnotic. MTUS /ACOEM does not discuss Ambien, so ODG guidelines were consulted. ODG states Zolpidem is for short-term use, usually 2-6 weeks. The records show that Ambien has been used every month since at least 10/20/13. The continued use of Ambien over 5-months is not in accordance with ODG guidelines. Recommendation is for non-certification. The request is not medically necessary and appropriate.

H-Wave Unit: One Month Trial: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 117-118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines for TENS, pg114-121, Transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: The patient is a 61 year-old male with an 8/26/2008 date of injury. The 3/17/14 medical report that was provided to UR for the 3/24/14 denial was not available for this IMR. According to the 2/19/14 pain management report from [REDACTED], the patient injured his lower back from carrying heavy equipment down three flights of stairs. He had been diagnosed with lumbar radiculitis; myofascial low back pain; left SI joint arthropathy; facet arthropathy; thrombocytopenia; and Hepatitis C. The request presented to IMR is for an H-wave unit one-month trial. The H-wave unit is an electrical stimulation device discussed in the MTUS guidelines under the transcutaneous electrotherapy section. MTUS for H-wave states: Not recommended as an isolated intervention, but a one-month home-based trial of H-Wave stimulation may be considered as a noninvasive conservative option for diabetic neuropathic pain

(Julka, 1998) (Kumar, 1997) (Kumar, 1998), or chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration, and only following failure of initially recommended conservative care, including recommended physical therapy (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS). On 2/19/14, the physician states the patient trialed a TENS home device without improvement, and has had PT and medications, and is being treated within an evidence-based functional restoration approach, including a directed home exercise program. The criteria for a 1-month trial of H-wave have been met. Recommend authorization. The request is medically necessary and appropriate.

Terocin Cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 111-113. Decision based on Non-MTUS Citation <http://www.drugs.com/pro/terocin.html>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines pg 111-113 Topical Analgesics Page(s): 111-113.

Decision rationale: The patient is a 61 year-old male with an 8/26/2008 date of injury. The 3/17/14 medical report that was provided to UR for the 3/24/14 denial was not available for this IMR. According to the 2/19/14 pain management report from [REDACTED], the patient injured his lower back from carrying heavy equipment down three flights of stairs. He had been diagnosed with lumbar radiculitis; myofascial low back pain; left SI joint arthropathy; facet arthropathy; thrombocytopenia; and Hepatitis C. This IMR request is for necessity of Terocin cream. Terocin cream is a compounded topical medication containing methyl salicylate, Capsaicin, Menthol and Lidocaine. MTUS states these are recommended for neuropathic pain after failure of antidepressants or anticonvulsants and any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Terocin contains topical Lidocaine. MTUS specifically states, other than the dermal patch, other formulations of Lidocaine whether creams, lotions or gels are not approved for neuropathic pain. So a compounded topical cream that contains Lidocaine would not be recommended by MTUS criteria. Recommendation is for non-certification. The request is not medically necessary and appropriate.