

Case Number:	CM14-0070092		
Date Assigned:	07/14/2014	Date of Injury:	05/04/2010
Decision Date:	09/30/2014	UR Denial Date:	05/09/2014
Priority:	Standard	Application Received:	05/15/2014

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 & Rehabilitation, has a subspecialty in Pain 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:

The injured worker is a 64-year-old male who reported an injury on 05/04/2010 due to unspecified mechanism of injury. The injured worker complained of neck and shoulder pain along with right hand pain. The injured worker had a diagnoses of cervical spine strain, right shoulder impingement syndrome, lumbar radiculopathy, right hand internal derangement, and hernia status post repair. The physical examination to the cervical spine dated 02/25/2014 revealed paraspinal muscles tenderness, spasms, tenderness at the trapezius bilaterally. The thoracolumbar spine revealed tenderness and spasms to the paraspinal muscles. The right wrist revealed tenderness to palpation at the joint lines, first dorsal compartment tender to palpation. The past treatment included medication and physical therapy. The medications included Medrox ointment, hydrocodone, ketoprofen, orphenadrine, and omeprazole DR. The Request for authorization dated 07/14/2014 was submitted with documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medrox Ointment 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Salicylate, Topical Analgesic, Topical Capsaicin Page(s): 105, 111, 28.

Decision rationale: The request for Medrox Ointment 2 refills is not medically necessary. The California MTUS indicates that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety, are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Capsaicin: Recommended only as an option in patients who have not responded or are intolerant to other treatments. There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. Additionally it indicates that Topical Salicylates are approved for chronic pain. According to the Medrox package insert, Medrox is a topical analgesic containing Menthol 5.00% and 0.0375% Capsaicin and it is indicated for the "temporary relief of minor aches and muscle pains associated with arthritis, simple backache, strains, muscle soreness, and stiffness." Capsaicin is not approved and Medrox is being used for chronic pain, by the foregoing guidelines. The request did not address the frequency. As such, the request is not medically necessary.

Ketoprofen 75mg Capsule #30 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 11-112.

Decision rationale: The request for Ketoprofen 75mg Capsule #30 with 2 refills is not medically necessary. The CA MTUS states Ketoprofen is a Non FDA-approved agent. This agent is not currently FDA approved for a topical application. It has an extremely high incidence of photo-contact dermatitis. The guidelines do not recommend the Ketoprofen. The request did not address the frequency. As such, the request is not medically necessary.

Omeprazole DR 20mg #30 with 2 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, Gastrointestinal Symptoms Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects Page(s): 70.

Decision rationale: The request for Omeprazole DR 20mg #30 with 2 refills is not medically necessary. The California MTUS recommends proton pump inhibitors for the treatment of dyspepsia secondary to NSAID therapy. There has been a recommendation to measure liver transaminases within 4 to 8 weeks after starting therapy, but the interval of repeating lab tests after this treatment duration has not been established. Routine blood pressure monitoring is recommended. The documentation was not evident that the injured worker had a peptic ulcer or

gastrointestinal issues. The request did not address the frequency. As such, the request is not medically necessary.

Orphenadrine ER 100mg #60 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxant Page(s): 63-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASMODICS Page(s): 64-65.

Decision rationale: The request for Orphenadrine ER 100mg #60 with 2 refills is not medically necessary. The California MTUS indicate that Orphenadrine is used to decrease muscle spasm in conditions such as low back pain, although it appears that these medications are often used for the treatment of musculoskeletal conditions whether spasm is present or not. The mechanism of action for most of these agents is not known. Orphenadrine is similar to diphenhydramine, but has greater anticholinergic effects. The mode of action is not clearly understood. Effects are thought to be secondary to analgesic and anticholinergic properties. The guidelines indicate that orphenadrine is similar to diphenhydramine. The mechanism of action for most of these agents is unknown. The request did not indicate the frequency. As such, the request is not medically necessary.

Hydrocodone (Norco 5/325) #60 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management, Hydrocodone/Acetaminophen Page(s): 78, 91.

Decision rationale: The request for Hydrocodone (Norco 5/325) #60 with 1 refill is not medically necessary. The CA MTUS states Hydrocodone/Acetaminophen is indicated for moderate to moderately severe pain and there should be documentation of the 4 A's for Ongoing Monitoring including analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. The reported injury was in 2010. The clinical notes did not address any aberrant drug behavior or adverse side effects. The request did not address the frequency. As such, the request is not medically necessary.