MAXIMUS Federal Services

Case Number:	CM14-0083016		
Date Assigned:	07/21/2014	Date of Injury:	08/16/2012
Decision Date:	08/29/2014	UR Denial Date:	05/21/2014
Priority:	Standard	Application Received:	06/04/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 38-year-old male who reported an injury on 08/12/2012 after falling off a ladder, landing on his back and wrist. The injured worker had a history of lower back and wrist pain with diagnoses of fractured vertebrae, compression, and wrist sprain/strain. The magnetic resonance imaging (MRI) dated 08/16/2012 of the lumbar spine revealed a mild edema at the L1-2. The computerized tomography (CT) of the thoracic spine dated 09/17/2012 revealed a cervical spine chip fracture and a fracture at the L-2 region. The prior treatments included a back brace and at least 32 to 43 sessions of physical therapy. The physical examination dated 09/04/2013 of the lumbar spine revealed normal sensory at the L2 through the S1; motor examination revealed a 5/5 from the L2 to the S1; negative Babinski's bilaterally with a flexion of 45 degrees and extension of 10 degrees. The medications included naproxen, Fexmid, Doral, Protonix, and Menthoderm. The injured worker reported pain at 3/10 to 5/10 with medication. The treatment plan included refilling medications. The Request for Authorization dated 07/21/2014 was submitted with the documentation. No rationale for the medications was provide.

IMR ISSUES, DECISIONS AND RATIONALES

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

Protonix 20 mg, count 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, NSAID, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) Guidelines recommend the use of proton pump inhibitors if there is a history of gastrointestinal bleeding or perforations, a prescribed high dose of non steroidal anti-inflammatory drugs, and a history of peptic ulcers. There is also a risk of long-term utilization of the proton pump inhibitors greater than 1 year which has been shown to increase the risk of hip fracture. The documentation was not evident of the length of time the injured worker had been taking the Protonix. The documentation was not evident that the injured worker had a history of gastrointestinal bleeding or perforations. The frequency was not addressed. As such, the request is not medically necessary and appropriate.

Menthoderm TM Gel, 120 ml.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.physiciansproducts.net/joomla/index.php/topical-parin-creams/72-menthoderm.

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

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) states that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety; also, that they are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control; however, there is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended, therefore, is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. Per the guidelines above, Menthoderm is recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Per the documentation provided, the injured worker had not been on antidepressants or anticonvulsants. Furthermore, it is used for neuropathic pain. The documentation provided did not indicate that the injured worker had neuropathic pain. Topical analgesics not recommended. The request did not indicate the frequency or dosage. As such, the request the request is not medically necessary and appropriate.

Orphenadrine 100 mg, count 60.: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) Guidelines indicate that this drug 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. Per the clinical notes, there was no evidence as to the need for the Orphenadrine. The request did not indicate the frequency or dosage. As such, the request is not medically necessary and appropriate.