

Case Number:	CM14-0189023		
Date Assigned:	11/19/2014	Date of Injury:	12/03/1997
Decision Date:	01/08/2015	UR Denial Date:	10/14/2014
Priority:	Standard	Application Received:	11/12/2014

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 Family Medicine and is licensed to practice in New York. 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 member's date of injury is listed as December 3, 1997. The member reported that he had developed problems with his lungs and memory and could not tolerate any stressful work. If reported getting dizzy if he did any exercise. The workplace assembled speaker systems. They buy the parts and made the wooden cabinets. The speakers were then put together on an assembly line. They used a variety of hand tools as well as some liquid compounds to clean the cabinets. The member's assigned job was as production manager but he had a floor supervisor who actually worked the floor. The member personally performed no hands-on work. He spent half of his time in his office and half of his time taking care of day to day needs on the floor. He indicated he spent most of his time doing paperwork but could look out a glass window in his office to the assembly line. His office opened onto a closed hallway which leads through another door to the assembly area or the main office. Beginning in 1993-4 he became aware of a smell in the air in the assembly area and had pain in his legs and feet. Then in 1995 he was experiencing daily headaches as were most of the members on the assembly line, initially attributable to solvents and thinners. However a specific incident resulting in an event that was reported on the local news in which lots of employees experienced weakness, couldn't stand up and fire responded and eventually detected high levels of carbon monoxide. The final diagnosis was carbon monoxide poisoning. Eventually the propane lift trucks were found to be the source of the exposure. Until the forklifts were replaced with electric models the issue was managed through the use of fans and opening the doors when the carbon monoxide monitors began to sound the alarm. By Feb 1998 the electric lift trucks were reported to be in service. By this time the member had been evaluated by a provider who declared that the member was experiencing. Various episodes related to a series of complaints were subsequently attributed to the member's exposure to carbon monoxide. We do not have access to the actual results but only second hand

reports. They had been reported variously from 1.8 to 3.0 %. It should be noted that smokers will have a CO level up to 8%. Serious medical problems do not develop usually until the CO exceeds 20%. Additionally, if not tested in a timely manner, CO levels will return to normal within hours on room air and faster if on supplemental oxygen. Classically symptoms will include headache, nausea, lightheadedness and dizziness. Severe exposure can lead to the sudden onset of unconsciousness. The primary treatment provider appears to have begun seeing the member on or about 20 Jan 1998. February 3, 1998 diagnosed as having pneumonia treated with Ceftin. Injured worker was released to return to unrestricted duty on follow-up visit on February 24, 1998. Because of a constellation of concerns the member underwent multiple investigation and consultations with Neurology, Cardiology and Pulmonology. A note from the primary treatment provider on January 9, 1999 indicated the related diagnoses to include: Pulmonary disease secondary to mold exposure/chemicals (undefined), myotoxic and chemical exacerbation of central nervous system (CNS) problems. Myotoxosis and chemicals caused "pulmonary problems, immunological problems, chronic sinus problems, reactive airway disease and hypoxemia. We do not have any of the original pulmonary function studies but merely peak flow reports. No specific results are available to inform the putative fungal toxicity or chemical toxicity. Reported Spirometry suggests a restrictive but not obstructive defect with no reported benefit of bronchodilators. Later chemical pneumonitis was added to the plethora of diagnoses. Available blood work suggested that the only abnormalities were with the triglycerides and total cholesterol, all liver function tests being within normal limits. The member's problem list has continued to expand and there appears to be no evidence for control or resolution of any of the original concerns.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tizandine 4mg quantity 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxant.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part 2, Muscle Relaxant Page(s): 62, 66.

Decision rationale: Non-sedating muscle relaxants can be recommended with caution as second line options for short term treatment of acute exacerbations of pain with muscle spasm. In most cases they show no additional benefit beyond NSAID's in pain and overall improvement and no additional benefit in combination with NSAID's. Tizanidine has shown evidence for efficacy with myofascial pain syndrome and possibly fibromyalgia. It has been associated with somnolence, dizziness, weakness and hepatotoxicity. The physical examination reported does not articulate evidence for muscle spasm or breakthrough muscle spasm. It is only recommended to for short term use as well generally progressively losing any beneficial impact over the course of several days. Based on my review of the available information the requested medication is not medically necessary.

Lidocaine 5% patches quantity 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); Topical Analgesics

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part 2, Topical Analgesics Page(s): 111, 112.

Decision rationale: 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. In the management of chronic pain topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy. This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. Non-neuropathic pain: Not recommended. There is only one trial that tested 4% Lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo. The only FDA approved use for the patch is with post-herpetic neuralgia. Lidocaine topical is only FDA approved for use with pruritic/painful dermatoses. Therefore it would not be indicated for use in chronic pain. It is unclear from the notes what the intent was as the member did have musculo-skeletal issues extraneous to the initially documented complaint and the work related findings. Therefore, the request for Lidoderm Patch 5% is not medically necessary and appropriate.

Tiagabine 4mg quantity 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part 2, Antiepileptic Drugs Page(s): 16-22.

Decision rationale: An antiepileptic drugs whose primary indication is as an adjunct for managing partial seizures (AEDs). It has most recently been approved for management of neuropathic pain. While there is a listed diagnosis of fibromyalgia the diagnosis does not appear to have been supported by documented clinical findings available in the records. It may prove to be effective in neuropathic pain but its ultimate role requires further research and experience. In the interim, these agents should be used to treat neuropathic pain only when Carbamazepine, Gabapentin, Or Lamotrigine cannot be used. In the absence of evidence for failure with these other medications, the requested medication is not medically necessary.

Ergoloid MES 1mg quantity 300: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guideline Clearinghouse (NGC)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682097.html> 5Jan15

Decision rationale: The MTUS does not touch specifically on this product. It has been used in the past for management of dementia and age related cognitive impairment. It's mechanism of action has not been clarified. It has been promoted as a inotropic/neutraceutical "memory enhancer" without benefit of positive results from controlled trials. It is an ergot based compound that can lead to egotism associated with vasospasm and ischemic events. Several EU countries have banned this product because of the cited risks. The listed diagnosis of dementia/memory loss has never been clinically supported through comprehensive neuro-psychiatric testing. Therefore, this medication is not medically necessary.

Fexofenadine 60mg quantity 60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guideline Clearinghouse (NGC)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Manufacturers Insert

Decision rationale: The MTUS does not explicitly cover this class of agents. It is a second generation anti-histamine exhibiting fewer unwanted side effects. Its primary indication is to manage allergic rhinitis and particularly seasonal allergy. There is no formal documentation that would suggest the member has a diagnosis of allergic rhinitis. Therefore, the requested medication is not medically necessary.

Azelastine 137 quantity 30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guideline Clearinghouse (NGC)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Manufacturers Insert

Decision rationale: The MTUS does not explicitly cover this class of agents. It is nasal non-selective anti-histamine. Its primary indications are for allergic, seasonal and vaso-motor rhinitis. There is no formal documentation that would suggest the member has a diagnosis of allergic rhinitis. Therefore, Azelastine 137 is also not medically necessary.

Tranlycypromine 10mg quantity 30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guideline Clearinghouse (NGC)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part 2 Page(s): 13. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Manufacturers Insert

Decision rationale: Antidepressants are recommended as first line options for neuropathic pain. Tri-cyclics are generally considered to be first line agents. There is no evidence that first line drugs have failed for neuropathic pain or that the member convincingly has neuropathic pain. There appears to be no supportive evidence for a diagnosis of moderate to severe depression. This agent is an MAOI. When no other products were available to treat significant depression then the risks associated with the class of agent were warranted. In the face of a multitude of safer (if not more effective) products on the market there is little to no use for this drug. The list of drug interactions is almost endless. Sudden discontinuation has been associated with abrupt decompensation and suicidal. While early on in the course of this injured workers evaluation a psychiatric consultation was recommended there is no documentation of ongoing psychiatric care or failure of a more accepted spectrum of anti-depressants. In the face of this information this medication is not medically necessary and appropriate.