

Case Number:	CM15-0054154		
Date Assigned:	03/27/2015	Date of Injury:	08/12/2010
Decision Date:	05/18/2015	UR Denial Date:	03/10/2015
Priority:	Standard	Application Received:	03/23/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 male who reported injury on 08/12/2010. The date of birth was not provided. The mechanism of injury was cumulative trauma. The documentation of 02/18/2015 revealed the injured worker had no significant improvements since the last examination. There were spasms in the paraspinal muscles and tenderness to palpation in the paraspinal muscles. The injured worker had reduced sensation in the left L5 dermatomal distribution. The injured worker had a positive left sitting straight leg raise. The diagnoses included lumbar radiculopathy, cervical sprain, and contusion of face, scalp, and neck except eye. The treatment plan included omeprazole DR 20 mg 1 by mouth twice a day, orphenadrine ER 1 tablet by mouth at bedtime as needed, capsaicin 0.1% cream applied to affected area twice a day, and hydrocodone/APAP 10/325 mg 1 by mouth twice a day #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Capsaicin 0.1% Cream: 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 Topical Analgesic, Topical Capsaicin Page(s): 111, 28.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines indicate 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 1 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 was a lack of documentation of a trial and failure of antidepressants and anticonvulsants. There was a lack of documentation indicating the injured worker had not responded or was intolerant to other treatments. The request as submitted failed to indicate the body part to be treated, the frequency, and the quantity of medication being requested. Given the above, the request for capsaicin 0.1% cream is not medically necessary.

Orphenadrine ER 100mg, #30, 1 refill: 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 Muscle Relaxants Page(s): 63.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend muscle relaxants as a second line option for the short-term treatment of acute low back pain and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review failed to provide documentation of objective functional improvement. There was a lack of documentation indicating a necessity for 1 refill without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Orphenadrine ER 100mg, #30, 1 refill is not medically necessary.

Omeprazole DR 20mg, #30, 1 refill: 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 NSAIDS Page(s): 69.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend proton pump inhibitors for injured workers at intermediate risk or higher for gastrointestinal events. There was a lack of documentation indicating the injured worker was at intermediate or higher risk for gastrointestinal events. The efficacy for the requested medication was not provided. There was a lack of documentation indicating a necessity for 1 refill without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for omeprazole DR 20mg, #30, 1 refill is not medically necessary.

Hydrocodone/Acetaminophen (Norco) 10/325mg, #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 Medications for Chronic pain, ongoing management, opioid dosing Page(s): 60, 78, 86.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for hydrocodone/acetaminophen (Norco) 10/325mg, #60 is not medically necessary.