

Case Number:	CM14-0143763		
Date Assigned:	09/12/2014	Date of Injury:	08/09/2000
Decision Date:	10/10/2014	UR Denial Date:	08/28/2014
Priority:	Standard	Application Received:	09/04/2014

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 in Physical Medicine and Rehabilitation 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 51-year-old female who was injured on 08/09/00. The areas of the injury include neck, right elbow, bilateral wrists and hands. She has persistent neck pain radiating down to arms with numbness and tingling as well as weakness. She also has ganglion cyst in the wrist. She has stiffness and loss of range of motion. She had decreased cervical range of motion, decreased right wrist range of motion, decreased right shoulder, arm, forearm, wrist and hand palpatory tenderness to a moderate to severe degree, cervical palpatory tenderness of mild to moderate degree. Neck extension was 15 degrees and flexion 10 degrees. MRI of the neck in 2010 showed no disc herniation and some bulging at C3-C4 to C6-C7. EMGs obtained in 2010 were unremarkable with resolution of symptomatology noted in previous EMGs. She was prescribed Terocin patches #20 for topical relief, LidoPro lotion 4 ounces, mirtazapine 15 mg #30 for insomnia, Norflex 100 mg #60 for muscle spasms, Protonix 20 mg #60 for upset stomach, and diclofenac 100 mg #30 for inflammation. She underwent chiropractic sessions which she indicated were quite helpful. Diagnoses include disc diseases at C3-C4 to C6-C7, overuse of upper extremity right rather than left, right CTS and cubital tunnel-syndrome status post decompression with nerve studies showing resolution, mild ganglion cyst on dorsum of wrist, and left wrist pain. The request for Norflex 100mg #60, Protonix 20mg #60, Terocin patches #20, Lido Pro lotion 4 ounces, and Chiropractic x 12 visits were denied on 08/28/14 due lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norflex 100mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63.

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

Decision rationale: Orphenadrine (Norflex, generic available) 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. This medication has been reported in case studies to be abused for euphoria and to have mood elevating effects. In this case, the medical records do not document the presence of substantial muscle spasm refractory to first line treatments. The medical records do not demonstrate the patient presented with exacerbation unresponsive to first-line interventions. There is no evidence of significant improvement in function with prior use. Chronic use of muscle relaxants is not recommended by the guidelines. Therefore, the request is not medically necessary per guidelines.

Protonix 20mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPI Page(s): 68.

Decision rationale: According to the CA MTUS, Protonix (Pantoprazole) "PPI" is recommended for Patients at intermediate risk for gastrointestinal events. The CA MTUS guidelines state PPI medications may be indicated for patients at risk for gastrointestinal events, which should be determined by the clinician: 1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Treatment of dyspepsia secondary to NSAID therapy recommendation is to stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI. The guidelines recommend GI protection for patients with specific risk factors, however, the medical records do not establish the patient is at significant risk for GI events or any gastrointestinal complaints. Therefore, the medical necessity of Protonix has not been established according to guidelines.

Terocin patches #20: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111, 112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111.

Decision rationale: According to the references, Terocin patches contain lidocaine and menthol. The CA MTUS state only Lidocaine in the formulation of Lidoderm patch may be considered for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). The guidelines state no other commercially approved topical formulations of lidocaine are indicated for neuropathic pain. Only FDA-approved products are currently recommended. Topically applied lidocaine is not recommended for non-neuropathic pain. The medical records do not establish this topical patch is appropriate and medically necessary for this patient. The request of Terocin Patches is not medically necessary.

Lido Pro lotion 4 ounces: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111.

Decision rationale: LidoPro contains Capsaicin, lidocaine, menthol and methyl salicylate. According to the CA MTUS guidelines, topical analgesics are an option with specific indications, many agents are compounded as monotherapy or in combination for pain control. There is little to no research to support the use of many of these agents. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Lidocaine Indicated in Neuropathic pain and is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Per the guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Therefore, the request is not medically necessary according to the guidelines.

Chiropractic x 12 visits: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints,Chronic Pain Treatment Guidelines Chiropractic treatment Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chiropractic treatment Page(s): 30.

Decision rationale: According to the CA MTUS guidelines, chiropractic treatment may be appropriate for treatment of chronic pain patients, in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. For therapeutic care of the low back, the guidelines recommend a trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks, may be recommended. In this case, the injury is very old; there is no record of prior physical therapy progress notes with documentation

of any significant improvement in the objective measurements (i.e. pain level, range of motion, strength or function) to demonstrate the effectiveness of physical therapy in this injured worker. Furthermore, there is no mention of the patient utilizing an HEP (At this juncture, this patient should be well-versed in an independently applied home exercise program, with which to address residual complaints, and maintain functional levels). There is no evidence of presentation of an acute or new injury with significant findings on examination to warrant any treatments. Additionally, the request would exceed the guidelines recommendation. Therefore, the request is considered not medically necessary or appropriate in accordance with the guidelines.