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| Case Number: | CM15-0123908 | | |
| Date Assigned: | 07/08/2015 | Date of Injury: | 05/28/2014 |
| Decision Date: | 08/05/2015 | UR Denial Date: | 06/12/2015 |
| Priority: | Standard | Application Received: | 06/26/2015 |

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: Physical Medicine & Rehabilitation

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 29-year-old female who sustained an industrial injury on 5/28/2014 resulting in low back and left leg pain with reduced range of motion. She is diagnosed with lumbar disk herniation at L4-5, foraminal stenosis, lumbar sprain, sciatica, and acute bursitis tendonitis of the left knee. Treatment has included lumbar epidural steroid injection with no reported improvement; and, use of oral and topical pain and anti-inflammatory medications, with 50% pain reduction and increased ability to perform activities of daily living. The injured worker currently reports low back pain radiating down her bilateral extremities limiting activities of daily living. The treating physician's plan of care includes Dendracin 120mg, Omeprazole 20mg, and Lorazepam 1 mg. She is on work restrictions, but documentation does not state if she is presently working.

IMR ISSUES, DECISIONS AND RATIONALES

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

Dendracin 120mg (unspecified quantity): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Topical analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, pages 112-113.

Decision rationale: Per MTUS Chronic Pain Guidelines, the efficacy in clinical trials for topical analgesic treatment modality has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. There is little evidence to utilize topical compound analgesic over oral NSAIDs or other pain relievers for a patient with spinal and multiple joint pain without contraindication in taking oral medications. Dendracin's ingredients are methyl salicylate, benzocaine, menthol, capsaicin, dimethyl sulfoxide, aloe vera gel, zingiber extract, borage oil, boswellia serrata, soyalecithin, PEG 100, stearic acid, propylene glycol, cetyl alcohol & Poloxamer 407 is a non-prescription strength topical analgesic with no proven greater efficacy than any other over-the-counter pain cream. Guidelines specifically noted that Boswellia Serrata Resin (Frankincense) is not recommended for chronic pain and as criteria note that any compounded product that contains at least one drug (or drug class) that is not recommended, is therefore, not recommended. Boswellia serrata is not recommended and is also a component of Dendracin, thereby, the request for Dendracin Cream has not been established. Submitted reports have not adequately demonstrated the indication or medical need for this topical analgesic for this chronic injury without documented functional improvement from treatment already rendered. The Dendracin 120mg (unspecified quantity) is not medically necessary and appropriate.

Omeprazole 20mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular risk, Pages 68-69.

Decision rationale: Proton pump inhibitor (PPI) medication is for treatment of the problems associated with active gastric ulcers, erosive esophagitis, Barrett's esophagitis, or in patients with pathologic hypersecretion diseases. Although preventive treatment is effective for the mentioned diagnosis, studies suggest; however, nearly half of PPI prescriptions are used for unapproved or no indications. Per MTUS Chronic Pain Treatment Guidelines, the patient does not meet criteria for Omeprazole (Prilosec) namely reserved for patients with history of prior GI bleeding, the elderly (over 65 years), diabetics, and chronic cigarette smokers. Long term use of PPIs have potential increased risks of B12 deficiency; iron deficiency; hypomagnesemia; susceptibility to pneumonia, enteric infections, fractures, hypergastrinemia and cancer, and cardiovascular effects of myocardial infarction (MI). In the elderly, studies have demonstrated increased risk for Clostridium difficile infection, bone loss, and fractures from long-term use of PPIs. Given treatment criteria outweighing risk factors, if a PPI is to be used, omeprazole (Prilosec), lansoprazole (Prevacid), and esomeprazole (Nexium) are to be considered over second-line therapy of other PPIs such as pantoprazole (Protonix), dexlansoprazole (Dexilant), and rabeprazole (Aciphex). Submitted reports have not described or provided any GI diagnosis that meets the criteria to indicate medical treatment. Review of the records show no documentation

of any history, symptoms, or GI diagnosis to warrant this medication. The Omeprazole 20mg #60 is not medically necessary and appropriate.

Lorazepam 1mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation US National Library of Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines, page 23.

Decision rationale: Lorazepam (Ativan) is an anti-anxiety medication in the benzodiazepine family and like other benzodiazepines, act by enhancing the effects of gamma-aminobutyric acid (GABA) in the brain. GABA is a neurotransmitter (a chemical that nerve cells use to communicate with each other) which inhibits many of the activities of the brain. It is believed that excessive activity in the brain may lead to anxiety or other psychiatric disorders. Clonazepam also is used to prevent certain types of seizures. Lorazepam is used for the short-term relief anxiety symptoms, usually up to 4 weeks as long-term efficacy is unproven with risk of dependency. It is used for certain types of seizures, specifically petit mal seizures, akinetic seizures, and myoclonus, as well as Lennox-Gastaut syndrome. Submitted reports have not adequately addressed the indication for Lorazepam's continued use for the chronic injury nor is there documented functional efficacy from treatment already rendered. The Lorazepam 1mg #60 is not medically necessary and appropriate.