

Case Number:	CM15-0063743		
Date Assigned:	04/09/2015	Date of Injury:	07/27/2012
Decision Date:	06/04/2015	UR Denial Date:	03/24/2015
Priority:	Standard	Application Received:	04/03/2015

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, Arizona

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 38 year old male, who sustained an industrial injury on July 27, 2012. The injured worker reported twisting his lower back, then developed tightness and spasms in the lower back. The injured worker was diagnosed as having spondylolisthesis, lumbar spondylosis, and neural encroachment L3-S1. Treatment to date has included MRI, electromyography, acupuncture, physical therapy, home exercise, lumbar-sacral orthosis, TENS therapy, work modifications, lumbar epidural steroid injections, and medications. On March 12, 2015, the injured worker reported low back pain with bilateral lower extremities symptoms. The physical exam revealed lumbar spine tenderness, decreased range of motion, positive right straight leg raise for pain to foot, and positive left straight leg raise for pain to distal calf at 40 degrees. The treatment plan included oral pain, non-steroidal anti-inflammatory, proton pump inhibitor, and muscle relaxant medications. The requested treatments are omeprazole, cyclobenzaprine, Terocin Patch, and Terocin lotion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 47-48, Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: California MTUS Guidelines state, proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. In this case, there was no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. The medical necessity for the requested medication has not been established. Additionally, there is no frequency listed in the request. As such, the request is not medically necessary.

Cyclobenzaprine 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain), Cyclobenzaprine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: The California MTUS Guidelines state muscle relaxants are recommended as nonsedating second line options for short term treatment of acute exacerbations. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. There was no documentation of palpable muscle spasm or spasticity upon examination. The medical necessity for the ongoing use of this medication has not been established. In addition, guidelines do not recommend long term use of muscle relaxants. There is no frequency listed in the request. As such, the request is not medically necessary.

Terocin patch box #5: Upheld

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

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

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. In this case, there was no documentation of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. The medical necessity for the requested medication has not been established in this case. There is also no frequency listed in the request. As such, the request is not medically necessary.

Terocin lotion 120mg: Upheld

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

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

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. In this case, there was no documentation of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. The medical necessity for the requested medication has not been established in this case. There is also no frequency listed in the request. As such, the request is not medically necessary.