MAXIMUS Federal Services

Case Number:	CM13-0029591		
Date Assigned:	01/10/2014	Date of Injury:	07/21/2005
Decision Date:	03/24/2014	UR Denial Date:	09/09/2013
Priority:	Standard	Application Received:	09/26/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine 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 physician 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:

MRI lumbar spine revealed the distal cord and conus are normal in appearance. The tip of the conus is seen at the L1 level. T11-T12, T12-L1 and L1-2 no abnormalities are present. No significant canal or foraminal stenosis is appreciated. L2-L3, mild discogenic degenerative changes are present with disc dehydration. Minimal anterior disc osteophyte reaction is present. Minimal broad 2-3 mm posterior disc bulge is present. L3-4 There is similar mild discogenic degenerative changes with minimal anterior disc osteophyte response and bilateral posterolateral disc bulges that again cause some mild bilateral foraminal narrowing without nerve root abutment displacement or impingement. Central canal remains patent. L4-L5 moderate degenerative disc disease is present with anterior disc osteophyte response and small broad anterior disc protrusion. L5-S1 there is mild discogenic degenerative changes with mild broad posterior disc protrusion of 3-4 mm. STIR images demonstrate disc dehydration at L2-L3, L3-L4, L4-L5 and L5-S1. Objectively the patient had positive straight leg raises, spasms and pain with flexion and extension; decreased sensation on right S1 dermatome. 08/06/12 progress report indicated right foot pain, increased low back pain with positive straight leg raise on the right leg, right leg pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

60 Vicodin 5/500mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-82.

Decision rationale: As per MTUS chronic pain medical treatment guidelines continued use is recommended if there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. According to the medical records provided for review there is no evidence of improved functioning and/or reduced pain through prior use of this medication. It is unclear if the patient has returned to work or not. The request for Vicodin 5/500 mg, #60 is non-certified.

Terocin cream: Upheld

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

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

Decision rationale: Terocin cream is a topical pain medication that contains active ingredients methyl salicylate, capsaicin, menthol, and Lidocaine. This patient continues to have constant lower back pain radiating to right lower extremity. CA MTUS chronic pain medical treatment guidelines recommend topical lidocaine in the formulation of a dermal patch for neuropathic pain. No other commercially approved topical formulations of Lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Guidelines further indicate that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Thus, the request for Terocin cream is not medically necessary and appropriate. The request is non-certified.

Trepoxicam (Meloxicam/Trepadone): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-69.

Decision rationale: This patient was diagnosed with DJD ankle/foot and lumbar HNP. As per CA MTUS guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Guidelines also indicate that there is no evidence of long-term effectiveness for pain or function and FDA concluded that long-term clinical trials suggest that cardiovascular risk occurs with all NSAIDs. Additionally, trepadone is a medical food which is recommended for dietary management of a specific medical disorder, disease, or

condition for which there are distinctive nutritional requirements. The medical records provided for review do not document a specific rationale or requirement for the treatment with this medication, hence the request is non-certified.

Theramine: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chapter - Pain (Chronic), Medical Food

Decision rationale: CA MTUS guidelines do not have appropriateness of the request and hence ODG have been consulted. As per ODG, the medical foods are recommended for dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements. The medical records provided for review do not document a specific rationale or objective functional benefit requiring the use of Theramine. Therefore, the request is non-certified.