

Case Number:	CM13-0030232		
Date Assigned:	11/27/2013	Date of Injury:	05/12/2003
Decision Date:	01/22/2014	UR Denial Date:	09/13/2013
Priority:	Standard	Application Received:	09/27/2013

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 Physical Medicine and Rehabilitation, and is licensed to practice in California, Ohio, and Pennsylvania. 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:

The underlying date of injury in this case is 05/12/2003. Treating diagnoses include lumbosacral discopathy, probable facet arthropathy, lumbar degenerative disc disease, sleep disturbance, and depression. A prior physician review notes that this patient has been treated for chronic low back pain and bilateral lower extremity symptoms with complaints being lumbar muscle spasms and restricted lumbar range of motion, although without neurological deficits. This physician review concluded that a Lindora weight loss program was not consistent with current treatment records. The review also noted that there was documentation of at least 4 aquatic therapy sessions recently without significant improvement and additional aquatic therapy was not indicated. This review indicated that a hot and cold therapy unit was not recommended by treatment guidelines. Also this review concluded since opioid use is not indicated for this patient and there were multiple non-certifications for opioids in the past, a drug screening request was not indicated. That review also concluded that multiple topical agents were not indicated and also that long-term use of tizanidine was not supported. This review concluded that there was no quantifiable or documented evidence of pain relief for functional improvement for gabapentin, and there was no evidence of functional improvement from opioids and that the guidelines do not support the long-term use of benzodiazepines includes Xanax and that the guidelines supported Ambien only for short-term use. The provider in this case has submitted multiple utilization review appeals. Regarding the use of opioids, the provider opines that substantial improvement has been disregarded by the initial reviewer including the patient's ability to perform household activities and improvement in the patient's overall quality of life. The treating physician notes the patient is at increased risk of developing gastric side effects due to Norco and therefor

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective request for 10 additional weeks of Lindora medical weight loss program between 8/6/2013 and 10/27/2013: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Snow, W. Barry, P., Fitterman, N., Quaseem, A, & Weiss, K. (2005). Pharmacologic and surgical management of obesity in primary care: a clinical practice guideline from the American College of Physicians. *Annals of Internal Medicine*, 142(7), 525-31.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, pg. 127.

Decision rationale: This treatment request is not specifically addressed in the California Medical Treatment Utilization Schedule. The ACOEM Guidelines Chapter 7, page 127, indicate that "The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise." The guidelines implicitly infer that such consultation should be medically supervised and by a medically qualified individual. The medical records do not provide an indication at this time in terms of the specific qualification or degree of medical supervision for this requested weight loss program. Therefore, this request is not medically necessary.

Prospective request for 8 additional aquatic therapy sessions (through Align networks) between 8/6/2013 and 10/27/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Physical Medicine Page(s): 99.

Decision rationale: The Chronic Pain Medical Treatment Guidelines Section on Physical Medicine, page 99, recommends therapy "allow for fading of treatment frequency plus active self-directed home Physical Medicine." This is a notably chronic injury and the patient would be anticipated to have transitioned to independent rehabilitation by this time. The records do not provide an alternate rationale as to why additional supervised therapy would be indicated at this time. This request is not medically necessary.

Prospective request for 1 hot and cold therapy unit (through cypress care) between 8/6/2013 and 10/27/2013: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back-Lumbar & Thoracic (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48.

Decision rationale: The ACOEM Guidelines, Chapter 3 Treatment, page 48, states, "During the acute to subacute phases for a period of 2 weeks or less, physicians can use passive modalities such as application of heat and cold for temporary amelioration of symptoms and to facilitate mobilization and graded exercise." These guidelines, therefore, would support the use of thermal modalities briefly for a short period of time but do not support the use of such equipment in the current chronic setting. This request is not medically necessary.

Prospective request 1 urinalysis drug screen between 8/6/2013 and 10/27/2013: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute & Chronic), and Universtisy of Michican Health System Guidelines for Clinical care: Managing Chronic Non-terminal pain, including prescribing controlled substances (May 2009), pg. 33

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Drug Testing Page(s): 43.

Decision rationale: The Chronic Pain Medical Treatment Guidelines Section on Drug Testing, page 43, states that urine testing is "recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs." Given the extensive polypharmacy in this case with limited apparent benefit, the guidelines would support urine drug testing in order to understand patient use of both prescribed and non-prescribed medications. A prior review indicated that this drug screen was not indicated given non-certifications of medications previously. However, it still would be helpful to know what medications the patient is nonetheless using either on a prescribed or non-prescribed basis. This request is medically necessary.

prospective request for 1 prescription for Gabaketolido cream, #240gm (through Express Scripts) between 8/6/2013 and 10/27/2013: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines Section on Topical Analgesics, pages 111-113, states that "any compounded product that contains at least one drug

that is not recommended is not recommended...Gabapentin: There is no peer-reviewed literature to support its use...Ketoprofen: This agent is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis." Therefore, at least 2 component medications in this medication are specifically not supported by the guidelines. Overall, this request is not medically necessary.

Prospective request for 1 prescription for Exoten-C lotion 113ml (through Express Scripts) between 8/6/2013 and 10/27/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Topical Analgesics Page(s): 111.

Decision rationale: The Chronic Pain Medical Treatment Guidelines Section on Topical Analgesics, page 111, states, "the use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required." The medical records do not contain such details to support a rationale for this topical agent. This request is not medically necessary.

Prospective request for 120 Tizanidine 4mg (through Express Scripts) between 8/6/2013 and 10/27/2013: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Muscle Relaxants Page(s): 66.

Decision rationale: The Chronic Pain Medical Treatment Guidelines Section on Muscle Relaxants, page 66, states regarding tizanidine, "Eight studies have demonstrated efficacy for low back pain. One study demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first-line option to treat myofascial pain." A prior physician review stated that the guidelines do not support this medication for long-term use. Although the guidelines discouraged multiple other muscle relaxants for long-term use, this medication is specifically discussed for long-term use with multiple academic references to support its use. Particularly in this situation where multiple other drug classes have been recommended for taper or discontinuation, the guidelines do support tizanidine as medically necessary. This request is medically necessary.

Prospective request for 12- Gabapentin 600mg (through Express Scripts) between 8/6/2013 and 10/27/2013: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Anti-Epileptic Medications Page(s): 18.

Decision rationale: The Chronic Pain Medical Treatment Guidelines Section on Anti-Epilepsy Medications, page 18, states regarding gabapentin "has been considered as a first-line treatment for neuropathic pain." A prior peer review states that this medication is not medically necessary given the lack of objective functional improvement. The guidelines do not specifically require objective functional improvement. Reports of subjective benefit or patient reports of improved pain are sufficient in accordance with the guidelines with use of this medication. This medication would particularly be supported by the guidelines in a situation such as this where multiple other drug classes have been noncertified. Therefore, this request is medically necessary.

Prospective request for 60 Norco 10/325mg (through Express Scripts) between 8/6/2013 and 10/27/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Opioids/Ongoing Management Page(s): 78.

Decision rationale: The Chronic Pain Medical Treatment Guidelines Section on Opioids/Ongoing Pain Management, page 78, recommends "Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects." The medical records in this case contain very limited information to support functional benefit or rationale overall for opioid use in this case. The 4 domains of opioid monitoring discussed in the medical guidelines have not been met. This request is not medically necessary.

Prospective request for 30 Xanax ER 1mg (through Express Scripts) between 8/6/2013 and 10/27/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Benzodiazepines Page(s): 24.

Decision rationale: The Chronic Pain Medical Treatment Guidelines Section on Benzodiazepines, page 24, states, "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence...Chronic benzodiazepines are the treatment of choice in very few conditions." This treatment, therefore, is not supported on a chronic basis. The records do not provide a rationale for an exception to these guidelines. This request is not medically necessary.

Prospective request for 30 Ambien 10mg (through Express Scripts) between 8/6/2013 and 10/27/2013: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment of Workers' Compensation, Pain/Insomnia Treatment

Decision rationale: This medication is not specifically discussed in the California Medical Treatment Utilization Schedule. The Official Disability Guidelines/Treatment of Workers' Compensation/Pain/Insomnia Treatment, states, "Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days)." However, based on the medical record submitted for review, it is not clear why an exception would be indicated to support the use of this medication on a chronic basis. Therefore, the guidelines and records do not support this request. This treatment request is not medically necessary.