MAXIMUS Federal Services

Case Number:	CM13-0035626		
Date Assigned:	12/13/2013	Date of Injury:	01/19/2010
Decision Date:	09/05/2014	UR Denial Date:	09/25/2013
Priority:	Standard	Application Received:	10/17/2013

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 Pain Management 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 34-year-old female who sustained cumulative trauma injuries from January 19, 2010 through July 10, 2010. Her working diagnoses are: headache, cervical radiculitis, and thoracic sprain/strain, lumbar radiculopathy, left shoulder sprain/strain, stress, idiopathic peripheral autonomic neuropathy, and unspecified disorder of autonomic nervous system. She has a history of being involved in a motor vehicular accident in 2006 and underwent chiropractic treatment to the neck for this. She reported no residual symptoms.Since the date of injury, the injured worker has been provided with treatments including pain medications, transcutaneous electrical nerve stimulation unit, and trigger point injections which did not provide prolonged relief. Review of the injured worker's evaluation reports from her treating physician from April 10, 2013 through June 12, 2013 indicate the injured worker primarily complained of persisting neck and low back pain rated as 7/10. She reported her pain was "getting worse" and epidural injections provided in the past provided no substantial pain relief. She would like to try surgery. Medication regimen consisted of Naproxen 500 mg, Gabapentin 300 mg, Zolpidem Tartrate 10 mg, Norco 10/325 mg, and Carisoprodol 350 mg. Physical examination findings were consistent with tenderness over the posterior neck region and the lumbar region. Range of motion testing of the cervical and lumbar spines showed restriction in flexion, extension, bilateral rotation, and bilateral lateral bending. Random urine drug screens were performed during this period, as well and results revealed positive findings of analytes consistent with prescribed medications. Comprehensive evaluation by the treating physician on August 15, 2013 indicates complaints of headaches in the occipital region, persistent neck pain, low back pain with numbness and tingling sensation, and intermittent left shoulder pain. Epworth Sleepiness Scale was 1 out of 24. Cervical ranges of motion were mildly restricted. Left shoulder ranges of motion were moderately restricted. Lumbar ranges of motion were

severely restricted. Left shoulder depression was positive. Straight leg raise was positive on the left. Muscle testing was normal in the upper and lower extremities. The health care provider indicated the injured worker was to discontinue Norco due to medication tolerance.Cervical spine magnetic resonance imaging scan without contrast dated August 22, 2013 showed disc desiccation at C2-C3 down to C6-C7. At C3-C4, a broad-based disc herniation with bilateral uncovertebral joint degenerative changes which causes stenosis of the spinal canal and of the bilateral neural foramen that contacts the bilateral C4 exiting nerve roots was identified.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOT/COLD UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM) Guidelines, Hot Packs, Heat Wraps, and Moist Heat.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174.

Decision rationale: The American College of Occupational and Environmental Medicine guidelines recommend at-home applications of heat or cold packs, but if the physician is suggesting continuous flow hot and cold combination units, these would not be recommended. It is unclear in the medical records provided for review why the injured worker could not use local application of heat or ice packs to the affected regions versus the need for a hot and cold unit. Therefore, it can be concluded that the medical necessity of the requested hot/cold unit is not medically necessary at this time.

TENS UNIT AND SUPPLIES: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114.

Decision rationale: The Chronic Pain Medical Treatment Guidelines indicate that there should be evidence that other appropriate pain modalities have been tried and failed during medication and other ongoing pain treatment. A one-month trial period with a rental unit should be documented as an adjunct to ongoing modalities within a functional restoration approach with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function of the injured worker. In this injured worker's case, the medical documents indicate provision of transcutaneous electrical nerve stimulation unit in the past with no sustained therapeutic benefit. Further, there was no indication or mention of failure of rehabilitative modalities such as physical therapy, chiropractic treatment, acupuncture, and/or aquatic therapy to substantiate the use of a transcutaneous electrical nerve stimulation unit. Therefore, it can be

concluded that the medical necessity of the requested transcutaneous electrical nerve stimulation unit is not medically necessary at this time.

SOMA 350MG #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that Soma (Carisoprodol) is not indicated for long-term use and tapering should be individualized for each patient. Also, the Official Disability guidelines state that this medication is indicated only for acute pain in musculoskeletal conditions and provided as an adjunct treatment to rest and physical therapy. Review of the medical records indicates that the injured worker has been utilizing the requested medication much longer than guideline recommendations. There is a lack of documentation to support the continued use of Soma beyond the recommended time frame. Therefore, it can be concluded that the medical necessity of the requested Soma 350 mg #30 is not medically necessary.

Oxycodone 10mg #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids specific drug list, page 91 Opioids, long-term assessment, page 88 Opioids, criteria for use, page 78 Page(s): 91, 88, 78.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that Oxycodone is indicated for moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time. Furthermore, the guidelines indicate the recommendation of the 4 A's for ongoing monitoring of patients on Opioid analgesics with the 4 domains indicated as analgesia, activities of daily living, adverse reaction and aberrant drug taking behavior. Although reasonably indicated for the injured worker's complaints of pain, review of available medical records states that the injured worker was to discontinue Norco due to medication Opioid intolerance. Since weaning was suggested, appropriate tapering of Norco should have taken place prior to provision of a more potent opioid. Therefore, it can be concluded that the medical necessity of the requested Oxycodone 10 mg #90 is not medically necessary at this time.

TEROCIN 240ML: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: Terocin is a compounded formulation of Methyl Salicylate, Capsaicin, Menthol, and Lidocaine. The Chronic Pain Medical Treatment guidelines indicate that use of topical analgesics is largely experimental. The reference guidelines specify that if one drug or drug class in a compounded medication is recommended for non-certification, the entire formulation is not recommended. As per the Chronic Pain Medical Treatment guidelines it is recommended that topical Lidocaine in the form of a patch (Lidoderm) is used to address neuropathic pain and not recommended in non-neuropathic pain. The component capsaicin is recommended for use to those who are unsuccessful with conventional therapy and is indicated only for post-herpetic neuralgia, diabetic neuropathy, and post-mastectomy pain which the injured worker does not have. Methyl Salicylate is indicated only for short-term treatment of osteoarthritis and tendinitis. The injured worker has neither of these diagnoses. Further, she has not exhausted and failed the different modalities of conventional treatments including but not limited to the different medications available. There is also no evidence in the medical records that the injured worker has intolerance to oral analgesics. Therefore, it can be concluded that the medical necessity of the requested Terocin 240 ml is not medically necessary.

FLURBI (NAP) CREAM-LA 180GM: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: According to the Chronic Pain Medical Treatment guidelines, topical analgesics are recommended only within certain guidelines. Topical non steroidal anti-inflammatory drugs have been shown to be superior to placebo during the first two weeks of treatment and indicated for osteoarthritis. It is recommended for short-term use between 4 to 12 weeks. Topical treatment can result in blood concentrations similar to oral forms. Since Flurbiprofen is included in Flurbi (NAP) and non steroidal anti-inflammatory drugs are not indicated, any compound product that contains at least one drug that is not recommended is not recommended. Based from the medical records available, it did not appear the injured worker has a diagnosis that would indicate a need for Flurbiprofen. Additionally, the guidelines note that any other form of Lidocaine besides the Lidocaine patch is not recommended. Therefore, it can be concluded that the medical necessity of the requested Flurbi (NAP) cream-LA 180 gm is not medically necessary.

GABACYCLOTRAM 180GM: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, page 111-112 Page(s): 111-112.

Decision rationale: The Chronic Pain Medical Treatment guidelines state that any compounded product that contains at least one drug or drug class that is not recommended is not recommended. The guidelines note the topical use of Gabapentin is not recommended, as there is no substantial peer-reviewed literature to support its use. The guidelines also note there is no evidence of use of any other muscle relaxant as a topical product. As such, the reference guidelines do not recommend the use of topical Gabapentin and Cyclobenzaprine. Therefore, it can be concluded that the medical necessity of the requested Gabacyclotram 180 gm is not medically necessary.

GENICIN #90 CAPSULES: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate) Page(s): 50.

Decision rationale: According to the Chronic Pain Medical Treatment guidelines, glucosamine is recommended as an optional treatment specifically for patients with moderate knee osteoarthritis. Review of the injured worker's medical records indicate there is no recent documentation about knee pain, osteoarthritis or any reason why this medication would be medically appropriate for the injured worker. Therefore, it can be concluded that the medical necessity of the requested Genicin #90 capsules is not medically necessary.

SOMNICIN #30 CAPSULES: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Regarding the request for Somnicin, the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines are silent regarding this medication. A thorough search of the National Library of Medicine reveals no peer-reviewed scientific literature establishing that Somnicin is effective in the treatment of any disease or disorder. The Somnicin brand website identifies that this medication contains melatonin, 5-HTP, L-tryptopan, Vitamin B6, and magnesium. Therefore, this medication would be classified in the medical food class. Review of the California Chronic Pain Medical Treatment Guidelines does not provide criteria for the use of medical foods. The Official Disability Guidelines state that medical foods may be considered if they are labeled for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements. In this injured

worker's case, there is no indication in the available documentation that the injured worker has any specific nutritional deficits that needs to be addressed. Instead, the requested medication was prescribed to address the injured worker's sleeping disorder. However, there is no recent account as to need for this medication to address insomnia, absent response to sleep hygiene or recent comprehensive sleep evaluations. Review of the injured worker's medical evaluation shows an Epsworth Sleepiness Scale of 1 out 24, indicating normal levels. Furthermore, Somnicin contains Vitamin B6 which is not indicated for use in addressing insomnia or neuropathy as per the Official Disability Guidelines. Therefore, it can be concluded that the medical necessity of the requested Somnicin #30 capsules is not medically necessary.