

Case Number:	CM13-0043838		
Date Assigned:	03/03/2014	Date of Injury:	11/06/2008
Decision Date:	09/29/2014	UR Denial Date:	10/04/2013
Priority:	Standard	Application Received:	10/26/2013

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 Anesthesiology and Pain Medicine and is licensed to practice in Florida. 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 37-year-old male who reported an injury on 11/06/2008 due to an unspecified cause of injury. The injured worker had a history of neck pain and right arm pain. The injured worker had a diagnosis of radiculopathy. The medications included Norco, zolpidem, Theramine, Synovacin, orphenadrine, Ambien, and Terocin lotion. The MRI dated 2002 of the cervical revealed increased stenosis to the C6 and C7. The objective findings dated 08/06/2013 revealed normal range of motion to the neck, and right lateral bend. Biceps, triceps range of motion 0. Motor strength 5/5. Sensory on the left is normal, decreased on the right. The injured worker reported his neck pain a 3/10 in intensity. The treatment plan also included a special mattress, cervical pillow, home exercise program, consultation and medication. The Request for Authorization was not submitted with the documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO 10/325MG EVERY 6 HOURS AS NEEDED: 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 Norco; Ongoing Management Page(s): 75; 78.

Decision rationale: The request for NORCO 10/325 MG EVERY 6 HOURS AS NEEDED is not medically necessary. The California MTUS guidelines recommend short acting opioids such as Norco for controlling chronic pain. For ongoing management, there should be documentation of the 4 A's including analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. The injured worker reported a 3/10 for pain. The physical examination was vague and illegible. The documentation should include the activities of daily living, adverse side effects, and the aberrant drug taking behavior. The request did not address frequency. As such, the request is not medically necessary.

ZOLPIDEM TARTRATE 10MG, 1 TAB BEFORE BED: 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) Mental illness and Stress, Zolpidem (Ambien).

Decision rationale: The request for ZOLPIDEM TARTRATE 10 MG, 1 TAB BEFORE BED is not medically necessary. The Official Disability Guidelines do not recommended Zolpidem for long-term use, but recommended for short-term use. The clinical notes provided indicated that the injured worker was prescribed the zolpidem on 04/19/2014 and again on 07/16/2014. Per the guidelines, the zolpidem ER is indicated for short-term use. The clinical notes did not indicate that the injured worker had a history of insomnia. The request did not indicate frequency. As such, the request is not medically necessary.

THERAMINE CAPSULE 101.5MG, 2 CAPSULES IN AM AND 2 CAPSULES IN PM:
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 (Chronic) Medical Foods.

Decision rationale: The request for THERAMINE CAPSULE 101.5 MG, 2 CAPSULES IN AM AND 2 CAPSULES IN PM is not medically necessary. The Official Disability Guidelines recommended as indicated below. Definition: Defined in section 5(b) of the Orphan Drug Act (21 U.s.c.360ee (b) (3)) as "a food which is formulated to be consumed or administered entirely under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation." To be considered the product must, at a minimum, meet the following criteria: (1) the product must be a food for oral or tube feeding; (2) the product must be labeled for dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; (3) the product

must be used under medical supervision. Per the clinical note, the injured worker did not require tube feeding or meet the criteria for a medical disorder, disease, or condition in which there are distinctive nutritional requirements. The request did not address the frequency. As such, the request is not medically necessary.

SYNOVACIN 500MG, 1 TABLET THREE TIMES A DAY: 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): 70.

Decision rationale: The request for SYNOVACIN 500 MG, 1 TABLET THREE TIMES A DAY is not medically necessary. Recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. The clinical notes did not indicate that the injured worker had a history of osteoarthritis. As such, the request is not medically necessary.

SOMA 350MG, 1 TABLET EVERY 6 HOURS: 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 Page(s): 65.

Decision rationale: The request for SOMA 350 MG, 1 TABLET EVERY 6 HOURS is not medically necessary. Per the California MTUS Guidelines indicate that carisoprodol (Soma) is not recommended for longer than 2 to 3 weeks. Carisoprodol is metabolized to meprobamate anxiolytic that is a Schedule 5 controlled substance. Carisoprodol is classified as a Schedule 4 drug in several states, but not on a federal level. It has been suggested that its main effect is due to generalized sedation, as treatment of anxiety. This drug was approved for marketing before the FDA required clinical studies to prove safety and efficacy. Withdrawal symptoms may occur with abrupt discontinuation. Per the guidelines, Soma is not recommended for long-term use. As such, the request for SOMA 350 MG, 1 TABLET EVERY 6 HOURS is not medically necessary.

NEW TEROGIN LOTION 120ML, APPLY TWICE A DAY: 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 Salicylate; Topical Analgesic; Topical Capsaicin; Lidocaine Page(s): 105; 111; 28; 112.

Decision rationale: The request for NEW TEROGIN LOTION 120 ML, APPLY TWICE A DAY is not medically necessary. The California MTUS indicates that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Capsaicin: Recommended only as an option in patients who have not responded or are intolerant to other treatments. The California MTUS guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. California MTUS guidelines recommend treatment with topical salicylates. Per Drugs.com, Terogin is a topical analgesic containing capsaicin / lidocaine / menthol / methyl salicylate. As such, the request for NEW TEROGIN LOTION 120 ML, APPLY TWICE A DAY is not medically necessary.

SENTRA PM, 2 TABLETS BEFORE BED: 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: The request for SENTRA PM, 2 TABLETS BEFORE BED is not medically necessary. The Official Disability Guidelines indicate that Sentra PM is a medical food from [REDACTED], intended for use in management of sleep disorders associated with depression that is a proprietary blend of choline bitartrate, glutamate, and 5-hydroxytryptophan. The request did not address the dosage or duration. As such, the request for SENTRA PM, 2 TABLETS BEFORE BED is not medically necessary.

GLUCOSAMINE CAPSULES 500MG, 1 TABLET THREE TIMES A DAY: 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): 70.

Decision rationale: The request for GLUCOSAMINE CAPSULES 500 MG, 1 TABLET THREE TIMES A DAY is not medically necessary. Recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. The clinical notes did not indicate that the injured worker had a history of osteoarthritis. The request did not address the duration. As such, the request is not medically necessary.