

Case Number:	CM13-0053113		
Date Assigned:	12/30/2013	Date of Injury:	09/12/2012
Decision Date:	06/06/2014	UR Denial Date:	11/07/2013
Priority:	Standard	Application Received:	11/18/2013

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in Texas and Oklahoma. 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 patient is a 42-year-old male who reported an injury on 09/12/2012 due to lifting a heavy object which reportedly caused injury to his low back. The patient's treatment history included physical therapy, chiropractic care, medications, a home exercise program and epidural steroid injections. The patient's most recent clinical evaluation documented that the patient had 7 out of 10 for low back pain that radiated into the bilateral lower extremities. Physical findings included tenderness to palpation along the paraspinal musculature with limited range of motion of the lumbar spine and right hip. The patient's diagnoses included lumbar radiculopathy, lumbar disc protrusion, lumbar spondylosis, lumbar spinal stenosis and right hip internal derangement. The patient's treatment plan included continued medication usage and acupuncture to assist with pain control.

IMR ISSUES, DECISIONS AND RATIONALES

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

EXTRACORPOREAL SHOCKWAVE LITHOTRIPSY (ESWT) TO THE THORACIC AND LUMBAR SPINE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Gerdesmeyer (2003). Extracorporeal shock wave therapy for orthopedic conditions.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Shockwave Therapy.

Decision rationale: The California Medical Treatment Utilization Schedule does not address this request. The Official Disability Guidelines (ODG) does not recommend the use of shockwave therapy in the management of low back pain. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested extracorporeal shockwave therapy to the thoracic and lumbar spine is not medically necessary or appropriate.

URINE TOXICOLOGY WITH [REDACTED] EVERY 4-6 WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Opioids, On-Going Management Page(s): 78.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) does recommend ongoing drug testing for injured workers who are at risk for aberrant behavior and on opioid therapy. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's risk factors to support urine drug screens beyond what would be considered reasonable for a low risk patient. Additionally, the request is open-ended and vague, which does not clearly define treatment duration. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested urine drug screen with [REDACTED] every 4 to 6 weeks is not medically necessary or appropriate.

FLURBI(NAP) CREAM -LA 180GM: (FLURBIPROFEN 20% /LIDOCAINE 5% /AMITRIPTYLINE 4%): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Topical Analgesics Page(s): 111. Decision based on Non-MTUS Citation Skolnick, P. (1999). Antidepressants for the new millennium. European Journal of Pharmacology, 375:31-40.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) recommends the use of Flurbiprofen as a topical analgesic for short durations of treatment for injured workers who have failed to respond to or when oral formulations of non-steroidal anti-inflammatory drugs are contraindicated for depletion. The clinical documentation submitted for review does not indicate that the injured worker cannot tolerate oral formulation of this medication. Therefore, a topical application would not be supported. Additionally, the compounded medication includes lidocaine in a cream formulation. The California MTUS does not support the use of lidocaine in a cream formulation as it is not Food and Drug Administration

(FDA) approved to treat neuropathic pain. Also, California MTUS and Official Disability Guidelines (ODG) do not address topical antidepressants. However, peer reviewed literature does not support the use of topical antidepressants as there is little scientific evidence to support the efficacy and safety of this medication in this formulation. Additionally, there is no documentation that the injured worker has failed to respond to oral formulations of antidepressants. Also, the request as it is submitted does not clearly define a frequency, quantity, or body part. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested compounded cream (Flurbiprofen/Lidocaine/Amitriptyline) is not medically necessary or appropriate.

GABACYCLOTRAM 180GM: GABAPENTIN 10%-CYCLOBENZAPRINE 6%-TRAMADOL 10%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111. Decision based on Non-MTUS Citation LeBon, B., Zeppetella, G., Higginson, I. J., (2009). Effectiveness of topical administration of opioids in palliative care: a systematic review. Journal of pain and symptoms, Elsevier.

Decision rationale: The requested medication is a compounded medication that contains gabapentin, cyclobenzaprine, and Tramadol. The California Medical Treatment Utilization Schedule (MTUS) does not support the use of gabapentin or cyclobenzaprine in a cream formulation as there is little scientific evidence to support the efficacy and safety of these medications in this formulation. The California MTUS and Official Disability Guidelines (ODG) do not address opioids in a topical formulation. Peer reviewed literature does not support the use of opioids in a topical formulation. Additionally, the request as it is submitted does not clearly identify a frequency, treatment duration, or body part. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Gabacyclotram cream is not medically necessary or appropriate.

TEROCIN PATCH BOX (10 PATCHES) X 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

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

Decision rationale: This is a compounded medication that contains menthol, methyl salicylate, and capsaicin. The California Medical Treatment Utilization Schedule (MTUS) does support the use of menthol and methyl salicylate in the management of osteoarthritic pain. However, California MTUS does not support the use of capsaicin in a topical formulation unless there is documentation of failure to respond to all other first line chronic pain treatments. The clinical documentation submitted for review does not provide any evidence that the injured worker has

failed to respond to first line anticonvulsants or antidepressants. Therefore, the use of this medication would not be supported. Additionally, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Terocin patches #10 with one refill is not medically necessary or appropriate.

GENICIN #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 50.

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

Decision rationale: The California Medical Treatment Utilization Schedule does not address medical food. The Official Disability Guidelines (ODG) does not recommend the use of medical food unless there is a documented nutritional deficit that would benefit from the use of these regulated medications. The clinical documentation submitted for review does not provide any justification for the use of this medical food. As such, the requested Genicin #90 is not medically necessary or appropriate.

SOMNICIN #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Library of Medicine, Food and Drug Administration (FDA), <http://www.nappharm.com/compound-anxietyinsomnia/> and <http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?id=35944>.

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

Decision rationale: The California Medical Treatment Utilization Schedule does not address medical food. The Official Disability Guidelines (ODG) does not recommend the use of medical food unless there is a documented nutritional deficit that would benefit from the use of these regulated medications. The clinical documentation submitted for review does not provide any justification for the use of this medical food. As such, the requested Somnicin #30 is not medically necessary or appropriate.

TEROCIN CREAM 240ML: CAPSAICIN 0.025%-METHYL SALICYLATE 25%-MEHTOL 10%-LIDOCAINE 2.5%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112-113.

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

Decision rationale: The requested medication is a compounded topical analgesic that contains methyl salicylate, menthol, capsaicin, and lidocaine. The California MTUS does support the use of methyl salicylate and menthol in the management of osteoarthritic pain. However, the use of capsaicin should be limited to injured workers who have failed to respond to all other first line medications to include antidepressants and anticonvulsants. There is documentation that the injured worker has failed to respond to these medications. Additionally, the California MTUS does not recommend the use of lidocaine in a cream formulation as it is not Food and Drug Administration (FDA) approved to treat neuropathic pain. As such, the requested Terocin cream 240 ml is not medically necessary or appropriate. Additionally, the request as it submitted does not clearly identify a frequency, duration, or body part. In the absence of this information, the appropriateness of the request itself cannot be determined.

OMEPRAZOLE 20MG, #60: 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), Proton pump inhibitor.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Non-steroidal anti-inflammatory drugs (NSAIDs), Gastrointestinal (GI) symptoms & cardiovascular risk, pg. 69.

Decision rationale: The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 05/2013 due to gastrointestinal irritation secondary to medication. The California Medical Treatment Utilization Schedule (MTUS) recommends the use of gastrointestinal protectants be based on documentation of risk factors of gastrointestinal disturbances related to medication usage. The injured worker's most recent clinical documentation does not provide an adequate assessment of the injured worker's gastrointestinal system to support the injured worker is at continued risk for development for gastrointestinal symptoms related to medication usage. Therefore, ongoing use of this medication would not be supported. Additionally, the request as it is submitted does not clearly identify a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested omeprazole 20 mg #60 is not medically necessary or appropriate.

CYCLOBENZAPRINE HYDROCHLORIDE 7.5MG, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Muscle Relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Muscle Relaxants Page(s): 63.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) does not recommend muscle relaxants in the management of chronic pain. The use of muscle relaxants should be limited to short durations of treatment not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. The clinical documentation submitted for review does indicate the injured worker has been on a muscle relaxant since at least 04/2013. In the absence of documentation of acute exacerbations of chronic pain, further use of muscle relaxants would not be supported. Additionally, the request as it is submitted does not clearly identify a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested cyclobenzaprine 7.5 mg #60 is not medically necessary or appropriate.

PERCOCET 5/325MG, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Opioids, On-Going Management Page(s): 78.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) recommends ongoing use of opioids be supported by documentation of functional benefit, evidence that the injured worker is monitored for aberrant behavior, managed side effects, and a quantitative assessment of pain relief. The clinical documentation submitted for review does not provide any evidence of pain relief, or increased functional capabilities resulting from medication usage. Although there is documentation that the injured worker is monitored for aberrant behavior with urine drug screens, there is no documentation of an assessment of side effects of this medication. Therefore, continued use would not be supported. Additionally, the appropriateness of the request itself cannot be determined as there is no frequency provided. As such, the requested Percocet 5/325 mg #60 is not medically necessary or appropriate.

ESTAZOLAM 2MG, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Benzodiazepines. Decision based on Non-MTUS Citation <http://www.rxlist.com/prosom-drug.htm>.

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

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) does not recommend the extended use of benzodiazepines due to the high risk of psychological and physiological dependence. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration. Therefore, continued use would not be supported. Also, the request as it is submitted does not clearly identify a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Estazolam 2 mg #30 is not medically necessary or appropriate.

OFFICE VISITS WITH [REDACTED] EVERY 4-6 WEEKS: 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).

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

Decision rationale: The California Medical Treatment Utilization Schedule does not address this type of request. The Official Disability Guidelines (ODG) recommends ongoing office visits for injured workers that require chronic pain management and medication assessments. However, the request as it is submitted is vague and open ended. The appropriateness of follow up office visits must be determined at each visit. Therefore, ongoing visits are not supported. As such, the requested office visits with [REDACTED] every 4 to 6 weeks are not medically necessary or appropriate.

LSO BRACE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 318. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

Decision rationale: The American College of Occupational and Environmental Medicine (ACOEM) recommends the use of a back brace only in the acute phase of a patient's injury. The clinical documentation submitted for review does support that the patient is in a chronic phase of injury. There is no documentation that the patient has sustained an acute exacerbation to support the use of a back brace. As such, the requested LSO brace is not medically necessary or appropriate.

ACUPUNCTURE TWO (2) TIMES A WEEK FOR FOUR (4) WEEKS TO THORACIC AND LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) recommends acupuncture as an adjunct treatment to an active therapy program to assist with pain control and medication reduction. The clinical documentation submitted for review does not provide any evidence that the patient is currently participating in a home exercise program that

would benefit from an adjunct therapy such as acupuncture. Additionally, there is no documentation that a goal of treatment is to reduce the patient's medication intake. The California MTUS also recommends a trial of 6 visits of acupuncture to establish efficacy of this treatment modality. The requested 8 visits exceed this recommendation. There is no documentation to support extending treatment beyond guideline recommendations. As such, the requested acupuncture 2 times a week for 4 weeks to the thoracic and lumbar spine is not medically necessary or appropriate.