

Case Number:	CM13-0061134		
Date Assigned:	12/30/2013	Date of Injury:	02/09/2011
Decision Date:	06/11/2014	UR Denial Date:	11/20/2013
Priority:	Standard	Application Received:	12/04/2013

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 and Rehabilitation and is licensed to practice in Michigan, Pennsylvania and Texas. 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 57 year old female who sustained an injury on 02/09/11. The patient does have multiple dates of injury. This appears to have been a cumulative trauma injury as a result of repetitive hand and finger motions as well as multiple falls. The patient had been followed for complaints of constant headaches in the occipital region which were improved with the use of medications and therapy. The patient also reported chronic neck pain radiating to the head, bilateral shoulders, and down to the lower back. Low back pain was also described, more severe to the right side radiating to the lower extremities. There were also complaints of left shoulder pain, bilateral wrist, hand, and knee pain. The patient had been followed for complaints of depression and anxiety. Recent toxicology results from 09/11/13 reported negative findings for any medications. The patient is noted to have had a prior spinal fusion from L4 to S1 performed in June of 2011. There were recommendations in July of 2013 for removal of the spinal hardware followed by laminotomy and discectomy at L3-4. The most recent evaluation on 09/09/13 by [REDACTED] indicated the patient's current medications included Vicodin, Omeprazole, Zolpidem, Ibuprofen, Cyclobenzaprine, a stool softener, Duproton and Hyerohycine. On physical examination, there was tenderness to palpation in the cervical spine with limited range of motion. The patient exhibited loss of range of motion in the left shoulder with negative impingement signs. There was also bilateral loss of range of motion in the wrists with positive Tinel's and Phalen's signs noted. Positive Finkelstein's signs were also noted bilaterally. Mild weakness was present at the left deltoid. Reflexes were 2+ and symmetric. The patient was reported to have diminished sensation to light touch in a C6 nerve root distribution. In the lumbar spine, there was tenderness to palpation of the paravertebral musculature. Range of motion in the lumbar spine was restricted and straight leg raise was reported as positive bilaterally. There was mild loss of range of motion at the bilateral knees on flexion. No motor weakness or reflex changes were

noted in the lower extremities. The patient was reported to have diminished sensation to light touch in an L5 and S1 nerve root distribution bilaterally.

IMR ISSUES, DECISIONS AND RATIONALES

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

ACUPUNCTURE FOR THE CERVICAL AND LUMBAR SPINE-2 TIMES A WEEK FOR 4 WEEKS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: In regards to the request for acupuncture for both the cervical and lumbar spine 2 x a week for 4 weeks, the last evaluation provided for review by [REDACTED] not provide any specific goals set with this type of modality. Given the patient's date of injury, it is unclear how acupuncture therapy more than 3 years after the injury occurred would result in any substantial functional improvement. Given the limited indications for this treatment, this request is not medically necessary.

HOT AND COLD UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301.

Decision rationale: In regards to the request for a hot and cold unit, the clinical documentation submitted for review would not support its use. There is no indication that hot or cold units provide any substantial functional improvement as compared to standard hot and cold packs that are readily available over the counter. Although hot and cold therapy units are typically utilized in postoperative rehabilitation following knee surgery, there is no indication in the clinical records that the patient would have reasonably required this type of DME for chronic pain. Therefore, it is this DME is not medically necessary.

CYCLOBENZAPRINE HYDROCHLORIDE 7.5 MG, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS (FOR PAIN).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-64.

Decision rationale: In regards to the use of Cyclobenzaprine 7.5mg quantity 60, this reviewer would not have recommended this medication as medically necessary. The chronic use of muscle relaxers is not recommended by current evidence based guidelines. At most, muscle relaxers are recommended for short term use only. The efficacy of chronic muscle relaxer use is not established in the clinical literature. There is no indication from the clinical reports that there has been any recent exacerbation of chronic pain or any evidence of a recent acute injury. Therefore, this service is not medically necessary.

TEROCIN PAIN PATCH BOX: Upheld

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

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

Decision rationale: In regards to the use of Terocin patches, this reviewer would not have recommended this medication as medically necessary. The California MTUS Chronic Pain Treatment Guidelines and US FDA note that the efficacy of compounded medications has not been established through rigorous clinical trials. The FDA requires that all components of compounded topical medication be approved for transdermal use. The clinical documentation provided did not indicate that there were any substantial side effects with the oral version of the requested medication components. Therefore, this compound would not have been supported as medically necessary.

QUALITATIVE DRUG SCREEN: 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 CHAPTER, URINARY DRUG SCREENS.

Decision rationale: In regards to the request for a qualitative drug screen, the clinical documentation submitted for review does not support this study as medically necessary. The patient has already had 1 qualitative drug screen from 09/11/13 which showed no findings for any substances. No further clinical reports were available for review after September of 2013 to warrant further qualitative drug screens. Therefore, this service is not medically necessary.

TEROCIN 240 ML: CAPSAICIN 0.025% METHYL SALICYLATE 25% MENTHOL 10% LIDOCAINE 2.5%: Upheld

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

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

Decision rationale: In regards to the use of compounded Terocin cream, this reviewer would not have recommended this medication as medically necessary. The California MTUS Chronic Pain Treatment Guidelines and US FDA note that the efficacy of compounded medications has not been established through rigorous clinical trials. The FDA requires that all components of compounded topical medication be approved for transdermal use. The clinical documentation provided did not indicate that there were any substantial side effects with the oral version of the requested medication components. Therefore, this compound would not have been supported as medically necessary.

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

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

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

Decision rationale: The compounded medication that contained Flurbiprofen, Lidocaine, and Amitriptyline was not supported by current evidenced based guidelines. The California MTUS Chronic Pain Treatment Guidelines and US FDA note that the efficacy of compounded medications has not been established through rigorous clinical trials. The FDA requires that all components of compounded topical medication be approved for transdermal use. This compound contains Flurbiprofen and Amitriptyline which are not approved for transdermal use. The clinical documentation provided did not indicate that there were any substantial side effects with the oral version of the requested medication components. Therefore, this compound was not supported as medically necessary.

GABACYCLOTRAM 180 GMS: GABAPENTIN 10% CYCLOBENZAPRINE 6% TRAMADOL 10%: Upheld

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

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

Decision rationale: The compounded medication that contained Gabapentin, Cyclobenzaprine, and Tramadol was not supported by current evidenced based guidelines. The California MTUS Chronic Pain Treatment Guidelines and US FDA note that the efficacy of compounded medications has not been established through rigorous clinical trials. The FDA requires that all components of compounded topical medication be approved for transdermal use. This compound contains Gabapentin, Cyclobenzaprine, and Tramadol which are not approved for transdermal

use. The clinical documentation provided did not indicate that there were any substantial side effects with the oral version of the requested medication components. Therefore, this compound was not supported as medically necessary.

SOMNICIN #30 CAPSULES: MELATONIN 2 MG 5HTP 50 MG L TYPTOPHEN 100 MG PYRIDOXINE 10 MG MAGNESIUM 50 MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation DRUGS.COM.

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

Decision rationale: In regards to the request for Somnicin, quantity 30, this medication would not be supported as medically necessary. Somnicin is a medical food utilized as a sleep aid. There was no indication from the clinical reports that the patient has failed other standard oral medications for sleep. There is no nutritional deficit identified in the clinical record that would support the use of this medical food. Given that guidelines do find medical foods as largely experimental and investigational and as there are no clear indications for its use in this case, this service is not medically necessary.

1 CC B-12 INJECTION IM: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG PAIN CHAPTER VITAMIN B.

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, VITAMIN B.

Decision rationale: In regards to a B12 injection, this reviewer would not have recommended this procedure as medically necessary. There was no indication from the clinical reports of a Vitamin B12 deficiency. The efficacy of Vitamin B12 in the treatment of chronic pain is not well established in the clinical literature. Therefore, this service is not medically necessary.