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| Case Number: | CM13-0064851 | | |
| Date Assigned: | 01/03/2014 | Date of Injury: | 02/12/2003 |
| Decision Date: | 03/27/2014 | UR Denial Date: | 11/27/2013 |
| Priority: | Standard | Application Received: | 12/12/2013 |

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 Internal Medicine, 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 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 patient is a 65 year old female who was injured on 02/12/2003 while she was lifting heavy boxes when she injured her lower back and neck. Prior treatment history has included lumbar epidural steroid infusion 2005, chiropractic treatment, physical therapy and LESI (multiple). The patient received an injection of Toradol and vitamin B-12 complex on 10/28/2013 and 09/27/2013. The patient received an injection of Toradol on 08/02/2013. Diagnostic studies reviewed include MRI of the lumbar spine performed 07/06/2010 was reviewed. MRI of the lumbar spine without contrast performed on 03/11/2013 revealed appearances were unchanged since 04/2012. X-ray of the lumbar spine (Flex/Ext) performed 01/18/2013 revealed discogenic spondylosis, mostly marked at L5-S1 and apophyseal arthrosis, L5-S1. A drug test performed on 08/02/2013 noted hydrocodone reported as prescribed. The analysis revealed there was no hydrocodone detected. Ranitidine detected by GC/MS; not reported as prescribed. A psychological assessment review, dated 02/06/2013, was administered as part of a comprehensive pain management evaluation. A PR-2 dated 10/28/2013 noted the patient to have complaints of increased symptomatology to the low back with some numbness and tingling to the lower extremities. She rated her low back, leg and hand pain as 8/10, while her neck and foot pain was 6/10. She was taking Norco which helped relieve her pain. She was currently not attending any type of therapy. Objective findings on examination of the lumbar spine revealed spasm and tenderness to the Paralumbar musculature. Sciatic stretch was positive. There was reduced range of motion, with pain on motion. Based on the patient's most recent urinalysis, the results showed inconsistencies regarding hydrocodone. The patient did take Norco on an as-needed basis. She had 60 for the past two months from date 10/28/2012, which she had not used at all. A PR-2 dated 09/27/2013 documented the patient to have complaints of ongoing pain to the low back and to the bilateral lower extremities. A PR-2 dated 08/02/2013 documented the

patient to have complaints of continued frequent exacerbation of pain within the low back. She also had bilateral lower extremity radiculopathy that continued to flare up. Objective findings on exam revealed tenderness to palpation over the paraspinal musculature and also spinous process. The patient also had bilateral sciatic notch tenderness, as well as positive straight leg raise test

IMR ISSUES, DECISIONS AND RATIONALES

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

Vitamin B-12 intramuscular injection: 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, Pain, section on Vitamin B, and the Aetna Clinical Policy Bulletin, Vitamin B-12 Therapy, Number 0536

Decision rationale: There were no indications for Vitamin B-12 therapy in the CA MTUS guidelines. The Official Disability Guidelines simply states that Vitamin B-12 injections are not recommended but are frequently used for treating peripheral neuropathy although its efficacy is not clear. Further guidelines were found which go into greater detail. According to the Aetna policy, vitamin B-12 injections are medically necessary only for current or previously documented B-12 deficiency and any of the following diagnoses and conditions: Anemia, GI disorders, Neuropathy (Acute phase or acute exacerbation of a neuropathy due to malnutrition or alcoholism*; or Neuropathies associated with pernicious anemia (Addisonian anemia, Biermer's anemia); or Posterolateral sclerosis), Dementia secondary to vitamin B-12 deficiency, Hemocystinuria, Members receiving methotrexate or pralatrexate (Folotyn), Members receiving pemetrexed (Alimta). There is no indication in the medical records provided that the patient has a B-12 deficiency, the injections were instead delivered to the patient "for symptomatic relief". Further, administration of the injections for more than 2-3 months is subject to review to ascertain if abnormalities have improved and to decide whether continued treatment is medically necessary. The first note of injection was 09/27/2013 and there have been no improvements in symptoms or documentation of required deficiency testing. The request for a Vitamin B-12 intramuscular injection is not medically necessary and appropriate.

1 prescription of compounded Fluriflex 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): 111-113.

Decision rationale: Per the MTUS Chronic Pain Guidelines, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." One of the components of this topical medicine is Cyclobenzaprine which not a recommended

ingredient for use in compounded treatments. Consequently, the request is not medically necessary and appropriate.

1 prescription of compounded TGIce 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): 111-113.

Decision rationale: Per the MTUS Chronic Pain Guidelines, topical analgesics are recommended as an option but they are largely experimental. Many agents are compounded for pain control although there is very little to no research to support the use of many of the agents. The active agents in the requested TGIce 180mg are not known and TGIce is found through the FDA as an approved compounded product. The request for 1 prescription of compounded TGIce 180gm is not medically necessary and appropriate.

A series of 8 physical therapy sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: According to the MTUS Chronic Pain Guidelines, "Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort." The medical records provided for review report the patient has had prior physical therapy but there is no documentation to show the benefits of the treatment. The patient has had the same steady complaints of pain and positive objective findings throughout the records. Therefore, the request is not medically necessary and appropriate.