MAXIMUS Federal Services

Case Number:	CM14-0001745		
Date Assigned:	01/22/2014	Date of Injury:	12/13/2012
Decision Date:	06/10/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/06/2014

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 Anesthesiologist, has a subspecialty in 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 51 year old male with a reported date of injury on 12/13/2012; the mechanism of injury was not provided. The clinical note dated 12/12/2013 noted that the injured worker had pain to the low back that was not relieved by epidural steroid injections and was seeking other forms of possible treatments as the injured worker expressed he was miserable. Objective findings included tenderness to the sciatic notch and decreased lumbar flexion. Additional findings included a lower extremity motor and sensory exam that was intact. An MRI dated 10/14/2013 revealed a disc spur complex that contacted both exiting L4 nerve roots right greater than left without impingement. The request for authorization for a lifetime gym membership, 18 visits of massage therapy, and an evaluation for functional restoration was submitted on 12/17/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

FUNCTIONAL RESTORATION PROGRAM EVALUATION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN PROGRAMS (FUNCTIONAL RESTORATION PROGRAMS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN PROGRAMS (FUNCTIONAL RESTORATION PROGRAMS) Page(s): 30-32.

Decision rationale: The request for a functional resoration program evaluation is non-certified. It was noted that the injured worker had pain to the low back that was not relived by epidural steroid injection. Objective findings included tenderness to the sciatic notch and decreased lumbar flexion. Additional findings included a lower extremity motor and sensory exam that was intact. An MRI dated 10/14/2013 revealed a disc spur complex that contacts both exiting L4 nerve roots right greater than left without impingement. The request for a functional restoration The California MTUS guidelines recommend the use of functional restoration programs where the programs are considered medically necessary by meeting all the criteria. This criteria includes an adequate and thorough evaluation has been made, including baseline functional testing, previous methods of treating chronic pain have been unsuccessful and there is an absence of other options, there has been a significant loss of ability to function independently resulting from the chronic pain, the injured worker is not a candidate for surgery, there is motivation to change, and predictors of success have been addressed. Based on the available documentation the medical necessity for a functional restoration program evaluation has not been established. There is a lack of evidence that the injured worker has exhausted all treatment options. Additionally, the specific tests which were being requested were not specified. As such this request is not medically necessary.

LIFETIME GYM MEMBERSHIP: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, CONTENTS, TREATMENT GUIDELINES, 18TH EDITION (2103 WEB) LOW BACK SECTION.

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, GYM MEMBERSHIPS.

Decision rationale: The request for a lifetime gym membership is not medically necessary. It was noted that the injured worker had pain to the low back that was not relieved by epidural steroid injection. Objective findings included tenderness to the sciatic notch and decreased lumbar flexion. Additional findings included a lower extremity motor and sensory exam that was intact. The Official Disability Guidelines state that gym memberships are not recommended as a medical prescription unless a documented home exercise program with periodic assessment and revision has not been effective. Additionally, treatment needs to be monitored and administered by medical professionals. There is a lack of evidence within the available documentation indicating the injured worker would be supervised by a medical professional during the gym sessions. Additionally, there was a lack of documentation indicating the injured worker previously participated in a home exercise program which had been revised and had not produced improvement. As such this request is not medically necessary.

MASSAGE THERAPY X 18: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, CONTENTS, TREATMENT GUIDELINES, 18TH EDITION (2103 WEB), PHYSICAL THERAPY GUIDELINES.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MASSAGE THERAPY Page(s): 60.

Decision rationale: The request for massage therapy x18 is not medically necessary. It was noted that the injured worker had pain to the low back that was not relieved by epidural steroid injection. Objective findings included tenderness to the sciatic notch and decreased lumbar flexion. Additional findings included a lower extremity motor and sensory exam that was intact. An MRI dated 10/14/2013 revealed a disc spur complex that contacts both exiting L4 nerve roots right greater than left without impingement. The California MTUS guidelines state that massage therapy is recommended as an adjunct therapy to other recommended treatments for relieving diffuse musculoskeletal symptoms but beneficial effects are registered only during treatment and there is a lack of lack of long-term benefits. Treatment should be limited to 4 to 6 visits. The documentation did not provide adequate evidence that this request was an adjunct therapy to another recommended treatment program. Additionally, the request exceeds the recommended total number of visits. As such this request is not medically necessary.

NEURONTIN 600MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIEPILEPSY DRUGS (AEDS) Page(s): 18.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 49.

Decision rationale: The request for Neurontin 600mg #90 is not medically necessary. It was noted that the injured worker had pain to the low back that was not relieved by epidural steroid injection. Objective findings included tenderness to the sciatic notch and decreased lumbar flexion. Additional findings included a lower extremity motor and sensory exam that was intact. It was noted that the injured worker had ben prescribed Neurontin since at least 01/17/2013. The California MTUS guidelines state that Gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The medical necessity for the use of Gabapentin has not been established. The documentation did not provide adequate evidence that the injured worker had symptomatology that would benefit from the use of this requested medication. Additionally, there is a lack of adequate evidence that the medication has provided adequate therapeutic response. Furthermore, there is no evidence of screening for possible side effects and/or appropriate drug use. As such this request is not medically necessary.

RESTORIL 30MG #15: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, CONTENTS, TREATMENT GUIDELINES, 18TH EDITION (2013WEB), PAIN- INSOMNIA TREATMENT.

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

Decision rationale: The request for Restoril 30mg #15 is not medically necessary. It was noted that the injured worker had pain to the low back that was not relieved by epidural steroid injection. Objective findings included tenderness to the sciatic notch and decreased lumbar flexion. Additional findings included a lower extremity motor and sensory exam that was intact. The California MTUS guidelines do not recommended benzodiazepines for long-term use because long-term efficacy is unproven and there is a risk of dependence. The guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. The medical necessity of this requested medication has not been established. The documentation did not provide adequate evidence that the injured worker had symptomatology that would benefit from the use of this requested medication. As such this request is not medically necessary.

TEROCIN PATCHES #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

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

Decision rationale: The request for Terocin Patches #30 is not medically necessary. It was noted that the injured worker had pain to the low back that was not relieved by epidural steroid injection. Objective findings included tenderness to the sciatic notch and decreased lumbar flexion. Additional findings included a lower extremity motor and sensory exam that was intact. Terocin patches are comprised of Lidocaine, capsaicin, menthol, and methyl salicylate. The California MTUS guidelines state that topical analgesics are recommended if they are approved for use and that any compounded product that contains at least one drug (or drug class) that is not recommended than the entire compounded product is not recommended. The guidelines state that the only recommended and FDA approved topical formulation of lidocaine is the Lidoderm patch. The guidelines also state that capsaicin is recommended for osteoarthritis only as a option in injured Final Determination Letter for IMR Case Number CM14-0001745 6 workers who have not responded to other treatments. Additionally, salicylate topicals are also recommended for chronic pain. It did not appear the injured worker had a diagnosis for which capsaicin would be indicated. As this requested medication composed of a non-recommended form of Lidocaine the compounded drug is not-recommended. As such this request is not medically necessary.

NORCO 10/325MG #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Short-Acting/Long-Acting Opioids Page(s): 75.

Decision rationale: The request for Norco 10/325mg #180 is not medically necessary. It was noted that the injured worker had pain to the low back that was not relieved by epidural steroid injection. Objective findings included tenderness to the sciatic notch and decreased lumbar flexion. Additional findings included a lower extremity motor and sensory exam that was intact. It was noted that the injured worker has been taking Norco since at least 12/19/2012. The California MTUS guidelines state that short-acting opioids are seen as an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain. The guidelines also state that on-going management of pain relief with opioids must include ongoing review and documentation of adequate pain relief, functional status, appropriate medication use, and side effects. The documentation did not provide adequate evidence that the medication has provided adequate therapeutic response. Additionally, there is no evidence of screening for possible side effects and/or appropriate drug use. As such this request is not medically necessary.