

Case Number:	CM14-0012080		
Date Assigned:	04/04/2014	Date of Injury:	06/24/2008
Decision Date:	08/05/2014	UR Denial Date:	01/15/2014
Priority:	Standard	Application Received:	01/30/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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:

Patient is a 50-year-old male who has submitted a claim for multilevel lumbosacral disc degeneration, thoracic myositis, lumbar myositis, thoracic muscle spasm, SI joint inflammation, post-traumatic anxiety, and depression associated with an industrial injury date of 06/24/2008. Medical records from 2013 were reviewed. Patient complained of mid-back pain rated 6/10 in severity, described as aching, dull, throbbing, radiating to the lower back. Aggravating factors included bending, housework, lifting, prolonged sitting, prolonged standing, and prolonged walking. Patient likewise complained of constant low back pain graded 7/10 in severity radiating to bilateral lower extremities. Physical examination showed painful and restricted range of motion of both the cervical and lumbar spine. Jamar hand dynamometer showed grip strength at right of 5-12-10 kg and at left of 75-82-85 kg. Kemp's test was positive on the left. Treatment to date has included use of a TENS UNIT, and medications such as naproxen, Gabapentin, Hydroxyzine, Tizanidine, Tramadol, Sentra, Theramine, and topical drugs. Utilization review from 01/15/2014 denied the retrospective requests for Prilosec 20 mg twice a day, #60; Zanaflex 4 mg twice a day, #60; Ultram 50 mg, 1-2 daily, #60; Theramine, 1 month supply; Sentra, 1 month supply; Atarax / Hydroxyzine 25 mg 3 x per day for post traumatic headaches; spinal manipulation 3 x 3; myofascial release 2 x 3; and E-stimulation 2 x3. Reasons for denial were not made available.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST (DISPENSED 12/11/13): PRILOSEC 20 MG TWICE A DAY, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI SYMPTOMS & CARDIOVASCULAR RISK.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms, and Cardiovascular Risk Page(s): 68.

Decision rationale: As stated on page 68 of CA MTUS Chronic Pain Medical Treatment Guidelines, clinicians should weigh the indications for NSAIDs against both GI and cardiovascular risk factors: age > 65 years, history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, or anticoagulant; or on high-dose/multiple NSAIDs. Patients with intermediate risk factors should be prescribed proton pump inhibitors (PPI). In this case, patient was prescribed Prilosec since August 2013. However, there was no subjective report that patient was experiencing heartburn, epigastric burning sensation or any other gastrointestinal symptoms that will corroborate the necessity of this medication. Furthermore, patient did not meet any of the aforementioned risk factors. The guideline criteria were not met. The progress report from 12/11/13 likewise is not made available for review. Therefore, the retrospective request (dispensed 12/11/13): Prilosec 20 mg twice a day, #60 was not medically necessary.

RETROSPECTIVE REQUEST (DISPENSED 12/11/13): ZANAFLEX 4 MG TWICE A DAY, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS (FOR PAIN); ANTISPASTICITY/ANTISPASMODIC DRUGS.

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

Decision rationale: According to page 63 of the CA MTUS Chronic Pain Medical Treatment Guidelines, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In this case, patient has been on Zanaflex since August 2013. Recent progress reports failed to provide evidence for muscle spasm. Long-term use is likewise not recommended. Progress report from 12/11/2013 is not made available for review. Therefore, the retrospective request (dispensed 12/11/13): Zanaflex 4 mg twice a day, #60 was not medically necessary.

RETROSPECTIVE REQUEST (DISPENSED 12/11/13): ULTRAM 50 MG, 1-2 DAILY, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TRAMADOL (ULTRAM (R)).

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

Decision rationale: As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, patient has been on Tramadol since August 2013. However, the medical records do not clearly reflect continued analgesia, continued functional benefit, or a lack of adverse side effects. MTUS Guidelines require clear and concise documentation for ongoing management. Progress report from 12/11/2013 likewise is not made available for review. Therefore, the retrospective request (dispensed 12/11/13): Ultram 50 mg, 1-2 DAILY, #60 was not medically necessary.

RETROSPECTIVE REQUEST (DISPENSED 12/11/13): THERAMINE, 1 MONTH SUPPLY: 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), Pain Chapter.

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

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Official Disability Guidelines, Pain section was used instead. ODG states that Theramine is a medical food that is a proprietary blend of GABA (gamma-aminobutyric acid) and Choline bitartrate, L-Arginine and L-Serine that is intended for use in the management of pain syndromes that include acute pain, chronic pain, fibromyalgia, neuropathic pain and inflammatory pain. However, it remains not recommended by the guidelines. In this case, patient has been on Theramine since October 2013. The rationale for its prescription is because of its anti-inflammatory effect without the concerning side effects of NSAIDs. However, patient is already on multiple pain medications comprising of muscle relaxants and opioids. Theramine remains not being recommended by the guidelines. Progress report from 12/11/13 likewise is not made available for review. Therefore, the retrospective request (dispensed 12/11/13): Theramine, 1 month supply was not medically necessary.

RETROSPECTIVE REQUEST (DISPENSED 12/11/13): SENTRA, 1 MONTH SUPPLY: 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), Pain Chapter, Sentra.

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, Sentra Other Medical Treatment Guideline or Medical Evidence http://www.ptlcentral.com/downloads/monographs/Sentra_AM_latest.pdf.

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and ODG was used instead. According to ODG, Sentra is intended for use in management of sleep disorders associated with depression. Sentra is a proprietary blend of Choline, Bitartrate, Glutamate, and 5-Hydroxytryptophan. There is no known medical need for Choline supplementation except for the case of long-term parenteral nutrition or for individuals with Choline deficiency secondary to liver deficiency. Glutamic Acid is used for treatment of Hypochlohydria and Achlorhydria including those for impaired intestinal permeability, short bowel syndrome, cancer and critical illnesses. 5-hydroxytryptophan has been found to be possibly effective in treatment of anxiety disorders, fibromyalgia, obesity, and sleep disorders. An online search showed that Sentra AM is a medical food that is intended for use in the management of chronic and generalized fatigue, fibromyalgia, post-traumatic stress syndrome (PTSD), neurotoxicity-induced fatigue syndrome, and impaired neurocognitive functions. In this case, patient has been on Sentra since October 2013 to improve quality of sleep. However, discussion concerning sleep hygiene was not evident in the medical records submitted. Moreover, progress report from 12/11/13 likewise is not made available for review. There is no documentation regarding nutritional deficiencies, or of the outlined conditions above. Therefore, the retrospective request (dispensed 12/11/13): Sentra, 1 month supply was not medically necessary.

RETROSPECTIVE REQUEST (DISPENSED 12/11/13): ATARAX / HYDROXYZINE 25 MG 3 X PER DAY FOR POST TRAUMATIC HEADACHES: 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, Anxiety medications in chronic pain; Weaning, opioids (specific guidelines).

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and ODG was used instead. According to ODG, Hydroxyzine may be used to control anxiety as an important part of chronic pain treatment. It can also be used to manage opioid withdrawal symptoms of insomnia and restlessness. In this case, patient has been on Hydroxyzine since August 2013 for headaches. However, there was no comprehensive discussion concerning characteristics of headaches. Recent progress reports failed to document functional benefits derived from its use. Progress report from 12/11/13 likewise is not made available for review. Therefore, the retrospective request (dispensed 12/11/13): Atarax / Hydroxyzine 25 mg 3 x per day for post traumatic headaches was not medically necessary.

SPINAL MANIPULATION 3 X 3:

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE; MANUAL THERAPY & MANIPULATION.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manipulation Therapy Page(s): 58-59.

Decision rationale: As stated on pages 58-59 of CA MTUS Chronic Pain Medical Treatment Guidelines, several studies of manipulation have looked at duration of treatment, and they generally showed measured improvement within the first few weeks or 3-6 visits of chiropractic treatment, although improvement tapered off after the initial sessions. There should be some outward sign of subjective or objective improvement within the first 6 visits for continuing treatment. In this case, patient complained of persistent mid- and lower back pain despite physical therapy and intake of medications. Manipulation therapy is a reasonable option at this time. However, the number of treatment sessions being requested exceeded guideline recommendation of an initial trial of 3 to 6 visits. Guideline criteria were not met. Therefore, the request for spinal manipulation 3 X 3 is not medically necessary.

MYOFASCIAL RELEASE 2 X 3: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301, Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60.

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

Decision rationale: According to page 60 of the CA MTUS Chronic Pain Medical Treatment Guidelines, massage therapy should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases. Massage is a passive intervention and treatment dependence should be avoided. This lack of long-term benefits could be due to the short treatment period or treatments such as these do not address the underlying causes of pain. In this case, patient complained of persistent mid- and lower back pain despite physical therapy and intake of medications. Manipulation therapy is a reasonable option at this time. However, there is no evidence presented that patient is currently participating in an active home exercise program, which is a necessary adjunct to massage therapy. Body part to be treated is likewise unspecified. Therefore, the request for myofascial release 2 x 3 is not medically necessary.

E-STIMULATION 2 X 3: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Electrical Stimulator Page(s): 44.

Decision rationale: Page 44 of CA MTUS Chronic Pain Medical Treatment guidelines state that electrotherapy has a variety of units, such as, transcutaneous electrical nerve stimulation / TENS, electroceutical therapy, galvanic stimulation, neuromuscular electrical stimulation, H-wave stimulation, interferential current stimulation, etc. These have different recommendations depending per type of unit. In this case, patient complained of persistent mid- and lower back pain despite physical therapy and intake of medications. Electrotherapy is a reasonable option. However, the request failed to specify body part to be treated. It is likewise non-specific to a single unit of electric therapy. The request is incomplete; therefore, the request for E-Stimulation 2 X 3 is not medically necessary.