

<b>Case Number:</b>	CM14-0018369		
<b>Date Assigned:</b>	04/21/2014	<b>Date of Injury:</b>	09/16/2011
<b>Decision Date:</b>	09/09/2014	<b>UR Denial Date:</b>	02/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2014

### 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 Physical Medicine and Rehabilitation 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 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 47-year-old female who reported an injury on 09/16/2011. The mechanism of injury was not stated. Current diagnoses include lumbar sprain/strain, status post right hip labral tear, right hip osteoarthritis, and right hip internal derangement. The injured worker was evaluated on 12/04/2013. The injured worker reported constant lower back pain and right hip pain. Physical examination was not provided on that date. Treatment recommendations included continuation of current medication and an MRI of the right groin.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**FOLLOW UP VISIT WITH DR. [REDACTED], (DOS: 1/24/14): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, TWC PAIN PROCEDURE SUMMARY.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**Decision rationale:** The ACOEM guidelines state that physician follow up can occur when a release to modified, increased, or full duty is needed, or after appreciable healing or recovery can be expected. As per the documentation submitted, the injured worker was evaluated by Dr.

██████████ on 01/15/2014. The medical necessity for an additional follow up appointment, 9 days later on 01/24/2014, has not been established. Therefore, the request for the follow up visit with Dr. ██████████ on 1/24/14 is not medically necessary.

**TEROCIN PAIN PATCH #20 (DOS: 12/4/13): 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.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no documentation of failure to respond to first-line oral medication prior to the initiation of a topical analgesic. Therefore, the request for the Terocin Pain Patch provided on 12/4/13 is not medically necessary.

**MEDS X 2 : TEROGIN PAIN PATCH #20 (DOS: 1/15/14): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no documentation of failure to respond to first-line oral medication prior to the initiation of a topical analgesic. Therefore, the requested Terocin Pain Patch provided on 1/15/14 is not medically necessary.

**ALPRAZOLAM 1MG #120 (DOS: 12/4/13): Upheld**

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

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is risk of dependence. The injured worker does not maintain a diagnosis of an anxiety disorder. The medical necessity for the requested medication has not been established. Additionally, the injured worker has utilized Xanax 1 mg since 09/2013. Guidelines do not recommend long-term

use of this medication. Therefore, the requested Alprazolam provided on 12/4/13 is not medically necessary.

**ALPRAZOLAM 1MG #120 (DOS: 1/3/14): 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 Page(s): 24.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is risk of dependence. The injured worker does not maintain a diagnosis of an anxiety disorder. The medical necessity for the requested medication has not been established. Additionally, the injured worker has utilized Xanax 1 mg since 09/2013. Guidelines do not recommend long-term use of this medication. Therefore, the requested Alprazolam provided on 1/3/14 is not medically necessary.

**GABADONE #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, TWC PAIN PROCEDURE SUMMARY.

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

**Decision rationale:** The ODG state that medical food is a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements are established by medical evaluation. The injured worker reports persistent lower back and right hip pain. However, there is no documentation of specific nutritional deficits that require a dietary supplement. Therefore, the request for Gabadone is not medically necessary.

**SENTRA PM #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, TWC PAIN PROCEDURE SUMMARY.

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

**Decision rationale:** The ODG states that Sentra PM is a medical food intended for use in management of sleep disorders associated with depression. There is no documentation of chronic insomnia or a diagnosis of depression. Therefore, the medical necessity for the requested medication has not been established. As such, the request for Sentra PM is not medically necessary.

**SENTRA AM #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, TWC PAIN PROCEDURE SUMMARY.

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

**Decision rationale:** The ODG states that medical food is a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements are established by medical evaluation. The injured worker reports persistent lower back and right hip pain. However, there is no documentation of specific nutritional deficits that require a dietary supplement. Therefore, the request for Sentra AM is not medically necessary.

**TREPADONE #120:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, TWC PAIN PROCEDURE SUMMARY.

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

**Decision rationale:** The ODG states that medical food is a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements are established by medical evaluation. The injured worker reports persistent lower back and right hip pain. However, there is no documentation of specific nutritional deficits that require a dietary supplement. Therefore, the request for Trepadone is not medically necessary.

**THERAMINE #90:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, TWC PAIN PROCEDURE SUMMARY.

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

**Decision rationale:** The ODG states that Theramine is not recommended. Theramine is a medical food that is intended for use in the management of pain syndromes. As guidelines do not recommend the use of this medication, the current request for Theramine is not medically necessary and appropriate.

**SOMNICIN #30 CAPSULES:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Drug Monograph.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Chronic Pain Chapter, Insomnia Treatment.

**Decision rationale:** The ODG state that insomnia treatment is recommended based on etiology. Empirically supported treatment includes stimulus control, progressive muscle relaxation, and paradoxical intention. There is no documentation of chronic insomnia or sleep disturbance. There is also no mention of failure to respond to non-pharmacologic treatment as recommended by the ODG. Therefore, the request for Somnicin is not medically necessary.

**GABACYCLOTRAM 180GMS:** 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 Page(s): 111-113.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Gabapentin is not recommended, as there is no peer-reviewed literature to support the use of any anti-epilepsy drug as a topical product. Muscle relaxants are also not recommended. Therefore, the request for Gabacyclotram is not medically necessary.

**FLURBI (NAP) CREAM- LA:** 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 Page(s): 111-113.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The only FDA-approved topical NSAID is Diclofenac. Therefore, the request for Flurbi (NAP) cream is not medically necessary.

**TEROCIN 240ML, 80 GMS:** 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 Page(s): 111-113.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no documentation of failure to respond to first-line oral medication prior to the initiation of a topical analgesic. Therefore, the request for Terocin is not medically necessary.

**PERCOCET 10/325MG #240:** 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 Page(s): 72-82.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the injured worker has utilized Percocet 10/325 mg since 09/2013. The injured worker continues to report persistent pain in the lower back and right hip. There is no evidence of objective functional improvement. Therefore, the request for Percocet is not medically necessary.