MAXIMUS Federal Services

Case Number:	CM14-0134173		
Date Assigned:	10/02/2014	Date of Injury:	09/28/2005
Decision Date:	11/03/2014	UR Denial Date:	07/28/2014
Priority:	Standard	Application Received:	08/19/2014

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 Family Medicine and is licensed to practice in North Carolina. 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 67 -year-old with a reported date of injury of September 28, 2005. The patient has the diagnoses of lumbar disc disease, lumbar radiculopathy and lumbar facet syndrome. Per the most recent progress reports provided for review by the primary treating physician dated June 23, 2014, the patient had complaints of neck and low back pain rated a 7/10. The physical exam noted antalgic gait on the left, diffuse tenderness over the lumbar paraspinal muscles, moderate facet tenderness at L4-S1, positive straight leg raise test on the left, bilateral positive Farfan test, decreased sensation on the left L4 dermatome and decreased lumbar range of motion. Treatment plan recommendations included request for epidural steroid injections, continuation of medications, home exercise program and continue to follow up with the patient's psychiatrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Care (12-visits, 3 times per week for 4 weeks): Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommend 4-6 visits with 1-2 visits for week. After six visits, care can continue if there are objective improvements. The request is for 12 visits. There is no explanation why this patient would require more sessions than what is recommended by the California MTUS Guidelines. Therefore, the request is not medically necessary

Urinalysis for Toxicology: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, steps to avoid misuse/abuse. Decision based on Non-MTUS Citation ODG, Pain Chapter, Urine Drug Testing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 76-84.

Decision rationale: The California MTUS Guidelines does recommend urine drug screens as part of the criteria for ongoing use of opioids when there are issues of abuse, addiction or poor pain control. There are no indications of any of these issues in the progress reports provided. Per the progress notes the patient is only currently taking Tramadol. For these reasons the establishment for the need of a urine drug screen has not been met. Therefore, the request is not medically necessary.

Prilosec (Omeprazole, 20mg, #30): 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 Page(s): 68.

Decision rationale: The California MTUS Guidelines states that patients are at risk for gastrointestinal events if the patient is: 1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). There is no documentation that places this patient at intermediate or severe gastrointestinal risk that would require a use of a PPI with NSAID therapy. There is also no mention of separate gastrointestinal disease that would require the use of a PPI independent of NSAID use. For these reasons the criteria as set forth above have not been met for the use of the medication. Therefore, the request is not medically necessary.

Flexeril (Cyclobenzaprine, 7.5mg, #30): 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 (for pain) Page(s): 63-66.

Decision rationale: The California MTUS Guidelines states that 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. The long-term chronic use of this medication is not recommended. The medication has not been prescribed for the acute flare up of chronic low back pain. Instead it is being used as a chronic treatment for pain. The criteria set forth for its use and the diagnoses indicated for its use per the FDA has not been met. Therefore, the request is not medically necessary.

Topical Compound Cream (Ketoprofen, 120gm, #1): 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 Anlagesics Page(s): 111-112.

Decision rationale: The California MTUS Guidelines state the topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. That they are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Guidelines also state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Ketoprofen is not currently FDA approved for a topical application. In addition, there is little evidence for the use of topical analgesic NSAIDs for the spine, hip or shoulder. This patient has lumbar spine complaints. For these reason the requested medication does not meet guideline recommendations. Therefore, the request is not medically necessary.

Topical Compound Cream (Gabapentin, 120gm, #1): 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: The California MTUS Guidelines state the topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. That they are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Guidelines also state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended, as there is no peer-reviewed literature to support the use. Therefore, the request 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 ODG, Pain Chapter, Theramine

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

Decision rationale: The California MTUS Guidelines and the ACOEM Practice Guidelines do not address specifically the requested medication. According to the Official Disability Guidelines, Theramine is a medical food that is a blend of GABA, choline bitartate, L-arginine and L-serine. It is intended for use in the management of pain syndromes. There is no high quality peer-reviewed literature that would suggest GABA is indicated for insomnia. According to guidelines, there is no known reason for choline supplementation except in the case of long term parenteral nutrition or in individual with deficiencies secondary to liver disease. In the absence of consistent evidence based support for the use of this medication, the request is not medically necessary.

Apptrim (#120): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter, medical food.

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,

Decision rationale: The California MTUS Guidelines and the ACOEM Practice Guidelines do not specifically address this medication. The medication is a blend of multiple ingredients. The Official Disability Guidelines states that a medical food is a food which is formulated to be consumed or administered entirely 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, based on recognized scientific principles, are established by medical evaluation. The patient has no indication of nutritional deficiencies or disease states that would cause such deficiencies. Therefore, the request is not medically necessary.