

Case Number:	CM14-0169312		
Date Assigned:	10/30/2014	Date of Injury:	01/22/2011
Decision Date:	12/12/2014	UR Denial Date:	10/07/2014
Priority:	Standard	Application Received:	10/14/2014

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 Orthopedic Surgery 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:

This is a 42-year-old male with a 1/22/11 date of injury. The mechanism of injury occurred when he went to put a wet vacuum, weighing 100 pounds, into a van and twisted and turned. He felt a sudden pain and pop in the low back. According to a 9/17/14 progress report, the patient reported thoracolumbar spine pain. He stated that he was doing poorly and was concerned about his back. Objective findings: tenderness and pain to the lumbar spine, thoracic and lumbar x-rays revealed slight increase of degenerative disc disease at L5-S1. Diagnostic impression: lumbar or lumbosacral intervertebral disc, degeneration of lumbar intervertebral disc without myelopathy and lumbago. Treatment to date: medication management, activity modification, surgery, chiropractic treatment, A UR decision dated 10/7/14 denied the requests for urine drug screen, consultation with spine specialist, compound Orphenadrine/Caffeine, compound Gabapentin/Pyridoxine, compound Omeprazole/Flurbiprofen, topical compound Flurbiprofen/Cyclobenzaprine/Menthol, Keratek gel, topical compound Diclofenac/Lidocaine, compound Hydrocodone/APAP/Ondansetron, Vicosetron 10/300/2, and 1 follow up evaluation. Regarding urine drug screen, the patient had a recent urine drug screen on 8/17/14, there was no indication to perform a repeat test at such a short time interval. Regarding consultation with spine specialist, there were no findings on examination or complaints that would warrant spine specialist consultation for this patient. Regarding Orphenadrine/caffeine, there were no guidelines to support the use of a compound of muscle relaxant and caffeine for chronic pain complaints. Regarding Gabapentin/pyridoxine, the patient does not demonstrate neuropathic pain and pyridoxine is not recommended for chronic pain complaints. Regarding topical compound medications, these contain products not supported by guidelines, therefore the medications themselves are not recommended. Regarding Keratek gel, there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis and there were no guidelines to support

Menthol as a topical product. Regarding Vicosetron (Hydrocodone/APAP/Ondansetron), there was no indication of recent surgery or plans for surgery and no evidence to support the use of an opiate compounded with an antiemetic. Regarding follow up evaluation, a follow-up does not appear appropriate since medications are non-certified based on lack of clinical findings for necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 222-238, Chronic Pain Treatment Guidelines 9792.24.2 Drug Testing, Urine Testing in Ongoing Opiate Management Page(s): 43, 78.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that a urine analysis is recommended as an option to assess for the use or the presence of illegal drugs, to assess for abuse, to assess before a therapeutic trial of opioids, addiction, or poor pain control in patients under on-going opioid treatment. However, in the present case, it is noted that the patient has had inconsistent urine drug screens dated 4/9/14 and 8/17/14. There is no documentation that the provider has addressed this issue. A specific rationale as to how obtaining another urine drug screen at such a short time would be beneficial to the patient's treatment plan was not noted, especially when the provider has not addressed the issue of inconsistent results. Therefore, the request for Urine drug screen was not medically necessary.

Consultation with spine specialist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 310.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.23 Clinical Topics. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 6, Independent Medical Examinations and Consultations, page(s) 127, 156 Official Disability Guidelines (ODG) Pain Chapter - Office Visits

Decision rationale: CA MTUS states that consultations are recommended, and a health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present or when the plan or course of care may benefit from additional expertise. However, in the present case, there are no subjective or objective findings documented that would warrant the need for consult with a spine specialist. A specific rationale identifying why this patient requires a consult with a spine specialist was not provided. Therefore, the request for Consultation with spine specialist was not medically necessary.

Compound Orphenadrine/Caffeine 50/10mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 63-66.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines, state that muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement, and no additional benefit has been shown when muscle relaxants are used in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. According to the records reviewed, this patient has been on Orphenadrine since at least 7/2/14, if not earlier. Guidelines do not support the long-term use of muscle relaxants. In addition, there is no documentation that the patient has had an acute exacerbation to his pain. Furthermore, a specific rationale as to why this patient requires a combination product containing Orphenadrine and caffeine was not provided. Therefore, the request for Compound Orphenadrine/Caffeine 50/10mg #60 was not medically necessary.

Compound Gabapentin/Pyridoxine 250/10mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Anti-epileptic drugs, Gabapentin Page(s): 16-18, 49. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA (Neurontin)

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines states that Gabapentin has been shown to be effective for the treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. However, in the present case, there is no documentation of subjective complaints or objective findings suggestive of neuropathy. In addition, a specific rationale identifying why this patient requires a combination product containing gabapentin and pyridoxine was not provided. Therefore, the request for Compound Gabapentin/Pyridoxine 250/10mg #60 was not medically necessary.

Compound Omeprazole/Flurbiprofen 10/100mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs; NSAIDs, GI Symptoms, and Cardiovascular Risk Page(s): 67; 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter - NSAIDs Other Medical Treatment Guideline or Medical Evidence: FDA (Omeprazole)

Decision rationale: CA MTUS states that NSAIDs are effective, although they can cause gastrointestinal irritation or ulceration or, less commonly, renal or allergic problems. Studies have shown that when NSAIDs are used for more than a few weeks, they can retard or impair bone, muscle, and connective tissue healing and perhaps cause hypertension. In addition, ODG states that there is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough pain. CA MTUS and the FDA support proton pump inhibitors in the treatment of patients with GI disorders such as; gastric/duodenal ulcers, GERD, erosive esophagitis, or patients utilizing chronic NSAID therapy. Omeprazole is a proton pump inhibitor, PPI, used in treating reflux esophagitis and peptic ulcer disease. There is no comment that relates the need for the proton pump inhibitor for treating gastric symptoms associated with the medications used in treating this industrial injury. In general, the use of a PPI should be limited to the recognized indications and used at the lowest dose for the shortest possible amount of time. However, in the reports reviewed, there is no documentation of significant pain relief or functional gains from the use of this NSAID. Guidelines do not support the ongoing use of NSAID medications without documentation of functional improvement. Furthermore, guidelines do not support the use of a combination product when separate formulations of the individual medications are available. Therefore, the request for Compound Omeprazole/Flurbiprofen 10/100mg, #60 was not medically necessary.

Topical compound Flurbiprofen/Cyclobenzaprine/Menthol 20%/10%/4% cream 180mg:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Topical Analgesics Page(s): 25, 28, 111-113.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in anything greater than a 0.025% formulation, baclofen, Boswellia Serrata Resin, and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. However, in the present case, guidelines do not support the use of cyclobenzaprine or the NSAID, flurbiprofen, in a topical formulation. A specific rationale identifying why this topical compounded medication would be required in this patient despite lack of guideline support was not provided. Therefore, the request for Topical compound Flurbiprofen/Cyclobenzaprine/Menthol 20%/10%/4% cream 180mg was not medically necessary.

Keratek gel 4oz (1 bottle): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 105, 111-113.

Decision rationale: CA MTUS states that topical salicylates are significantly better than placebo in chronic pain. However, while the guidelines referenced support the topical use of mental salicylates, the requested Keratek has the same formulation of over-the-counter products such as BenGay. It has not been established that there is any necessity for this specific brand name. However, a specific rationale identifying why this patient requires Keratek as opposed to an over-the-counter equivalent was not provided. Therefore, the request for Keratek gel 4oz (1 bottle) was not medically necessary.

Topical compound Diclofenac/Lidocaine 3%/5% 180mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Topical Analgesics Page(s): 25, 28, 111-113.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in anything greater than a 0.025% formulation, baclofen, Boswellia Serrata Resin, and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. However, in the present case, guidelines do not support the use of lidocaine in a topical cream/lotion formulation. A specific rationale identifying why this topical compounded medication would be required in this patient despite lack of guideline support was not provided. Therefore, the request for Topical compound Diclofenac/Lidocaine 3%/5% 180mg was not medically necessary.

Compound Hydrocodone 10/325mg/APAP/Ondansetron 300/2mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Opiates Page(s): 78-81. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA (Ondansetron)

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and

documentation of pain relief, functional status, appropriate medication use, and side effects. The FDA states that Ondansetron is indicated for prevention of nausea and vomiting caused by cancer chemotherapy, radiation therapy and surgery. However, in the reports reviewed, there is no documentation of significant pain reduction or improved activities of daily living. Guidelines do not support the continued use of opioid medications without documentation of functional improvement. There is no documentation of lack of aberrant behavior or adverse side effects, an opioid pain contract, or CURES monitoring. In addition, it is noted that the patient has had inconsistent urine drug screens dated 4/9/14 and 8/17/14. There is no documentation that the provider has addressed this issue. Furthermore, guidelines do not support the use of Ondansetron for prophylactic use of opioid-induced nausea or vomiting. Additionally, guidelines do not support the use of a combination product when separate formulations of the individual medications are available. Therefore, the request for Compound Hydrocodone 10/325mg/APAP/Ondansetron 300/2mg #60 was not medically necessary.

Vicosetron 10/300/2mg #40: 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)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Opiates Page(s): 78-81. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA (Ondansetron)

Decision rationale: According to the UR decision dated 10/7/14 Vicosetron is a combination product containing Hydrocodone, APAP, and Ondansetron. CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The FDA states that Ondansetron is indicated for prevention of nausea and vomiting caused by cancer chemotherapy, radiation therapy and surgery. However, in the reports reviewed, there is no documentation of significant pain reduction or improved activities of daily living. Guidelines do not support the continued use of opioid medications without documentation of functional improvement. There is no documentation of lack of aberrant behavior or adverse side effects, an opioid pain contract, or CURES monitoring. In addition, it is noted that the patient has had inconsistent urine drug screens dated 4/9/14 and 8/17/14. There is no documentation that the provider has addressed this issue. Furthermore, guidelines do not support the use of Ondansetron for prophylactic use of opioid-induced nausea or vomiting. Additionally, guidelines do not support the use of a combination product when separate formulations of the individual medications are available. Therefore, the request for Vicosetron 10/300/2mg #40 was not medically necessary.

Follow-up evaluation in six (6) weeks: 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)

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 - Office Visits

Decision rationale: CA MTUS does not address this issue. ODG states that evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, to monitor the patient's progress, and make any necessary modifications to the treatment plan. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. In the present case, it is noted that the provider has requested a follow-up visit in 6 weeks to check the patient's progress. However, because the medical necessity of the patient's medication regimen has not been established, the medical necessity of a follow-up visit cannot be established. Therefore, the request for Follow-up evaluation in six (6) weeks was not medically necessary.