

Case Number:	CM14-0037958		
Date Assigned:	07/28/2014	Date of Injury:	06/06/2013
Decision Date:	09/23/2014	UR Denial Date:	03/18/2014
Priority:	Standard	Application Received:	03/28/2014

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 & Rehabilitation, Pain Medicine 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 41-year-old male who reported an injury on 06/06/2013. The mechanism of injury was not provided. On 02/10/2014 the injured worker presented with complaints of constant low back pain. Upon examination, the lumbar spine range of motion values was 35 degrees of flexion, 10 degrees of extension, and 10 degrees of right lateral flexion and 10 degrees of left lateral flexion. There was tenderness over the lumbar spine with spasm. The diagnoses were lumbar radiculopathy, status post lumbar spine surgery 12/20/2013, and status post right wrist hand surgery 11/25/2013. Current medication included Terocin patches, topical analgesics, Theramine, Sentra, Gabadone and Norco. The provider recommended Theramine, Sentra AM and PM, Gabadone, Terocin, Flurbi (NAP) cream, Gabacyclotram, Genicin, Somnicin, Terocin patches and retrospective drug screen (date of service 02/10/2014). The provider's rationale was not provided. The Request for Authorization form was dated 03/11/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

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 Pain Chapter, Medical Foods.

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

Decision rationale: The request for Theramine #90 is not medically necessary. The Official Disability Guidelines state medical food is recommended when it is formulated to be consumed or administered entirely under the supervision of a physician, and intended for specific dietary management of a disease or condition for which distinctive nutritional requirements are required. The product must be a food for oral or tube feeding. The rationale for recommending medical food was not provided. Additionally, there is lack of evidence that the injured worker is recommended for specific dietary needs or distinctive nutritional requirements for a disease or condition. The provider's request does not indicate the dose or frequency of the medication in the request as submitted. As such, medical necessity has not been established.

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 Pain Chapter, Medical Foods.

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

Decision rationale: The request for Sentra AM #60 is not medically necessary. The Official Disability Guidelines state medical food is recommended when it is formulated to be consumed or administered entirely under the supervision of a physician, and intended for specific dietary management of a disease or condition for which distinctive nutritional requirements are required. The product must be a food for oral or tube feeding. The rationale for recommending medical food was not provided. Additionally, there is lack of evidence that the injured worker is recommended for specific dietary needs or distinctive nutritional requirements for a disease or condition. The provider's request does not indicate the dose or frequency of the medication in the request as submitted. As such, medical necessity has not been established.

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 Pain Chapter, Medical Foods.

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

Decision rationale: The request for Sentra PM #60 is not medically necessary. The Official Disability Guidelines state medical food is recommended when it is formulated to be consumed

or administered entirely under the supervision of a physician, and intended for specific dietary management of a disease or condition for which distinctive nutritional requirements are required. The product must be a food for oral or tube feeding. The rationale for recommending medical food was not provided. Additionally, there is lack of evidence that the injured worker is recommended for specific dietary needs or distinctive nutritional requirements for a disease or condition. The provider's request does not indicate the dose or frequency of the medication in the request as submitted. As such, medical necessity has not been established.

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 Pain Chapter, Medical Foods.

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

Decision rationale: The request for Gabadone #60 is not medically necessary. The Official Disability Guidelines state medical food is recommended when it is formulated to be consumed or administered entirely under the supervision of a physician, and intended for specific dietary management of a disease or condition for which distinctive nutritional requirements are required. The product must be a food for oral or tube feeding. The rationale for recommending medical food was not provided. Additionally, there is lack of evidence that the injured worker is recommended for specific dietary needs or distinctive nutritional requirements for a disease or condition. The provider's request does not indicate the dose or frequency of the medication in the request as submitted. As such, medical necessity has not been established.

Terocin 240 ml: 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.

Decision rationale: The request for Terocin 240 ml is not medically necessary. The California MTUS Guidelines state topical compounds are largely experimental in use, with few randomized control trials to determine efficacy or safety, and are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended is not recommended. The guidelines state that capsaicin is recommended only as an option if injured workers are not responsive or intolerant to other treatments. The guidelines state that Lidoderm is the only topical form of Lidocaine approved. The included medical documents do not indicate that the injured worker has not responded, or is intolerant to, other treatments. The guidelines do not recommend any other formulation of topical Lidocaine in any other form than Lidoderm. Included medical

documents lack evidence of an initial trial of antidepressants or anticonvulsants. The provider's request does not indicate the site that the cream is intended for, the frequency or the dose in the request as submitted. As such, medical necessity has not been established.

Flurbi (NAP) Cream LA 180gms: 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.

Decision rationale: The request for Flurbi (NAP) Cream LA 180gms is not medically necessary. The California MTUS Guidelines states that transdermal compounds are largely experimental in use with few randomized control trials to determine efficacy or safety. Topical analgesic is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 (or drug class) that is not recommended is not recommended. The guidelines note NSAIDs are recommended for osteoarthritis and tendinitis, in particular that of the knee, elbow, or other joints that amenable to topical treatment. It sacroiliac recommended for 4 to 12 weeks. There is little evidence to utilize topical NSAIDs for treatments of osteoarthritis of the spine, hip or shoulder. The injured worker's diagnosis was not congruent with the guideline recommendation for topical NSAIDs. Additionally, there is lack of evidence that the injured worker had failed a trial of either anticonvulsants or antidepressants. The provider's request does not include the site at which the cream is intended for or the frequency of the medication in the request as submitted. As such, medical necessity has not been established.

Gabacyclotram 180gms: 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.

Decision rationale: The request for Gabacyclotram 180gms is not medically necessary. The California MTUS Guidelines state that transdermal compounds are largely experimental in use, with few randomized control trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants or anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Many agents are compounded as monotherapy or in combination for pain control, including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, and adenosine. There is little to no research to support the use of many of these agents. There is lack of documentation that the injured worker had failed a trial of an antidepressant or anticonvulsant. Additionally, the provider's request does

not provide the site at which the cream is intended for, or the frequency of the medication in the request as submitted. As such, the request is not medically necessary.

Genicin #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back 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, Medical Food.

Decision rationale: The request for Genicin #90 is not medically necessary. The Official Disability Guidelines state medical food is recommended when it is formulated to be consumed or administered entirely under the supervision of a physician, and intended for specific dietary management of a disease or condition for which distinctive nutritional requirements are required. The product must be a food for oral or tube feeding. The rationale for recommending medical food was not provided. Additionally, there is lack of evidence that the injured worker is recommended for specific dietary needs or distinctive nutritional requirements for a disease or condition. The provider's request does not indicate the dose or frequency of the medication in the request as submitted. As such, medical necessity has not been established.

Somnicin #30: 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, Medical Food.

Decision rationale: The request for Somnicin #30 is not medically necessary. The Official Disability Guidelines state medical food is recommended when it is formulated to be consumed or administered entirely under the supervision of a physician, and intended for specific dietary management of a disease or condition for which distinctive nutritional requirements are required. The product must be a food for oral or tube feeding. The rationale for recommending medical food was not provided. Additionally, there is lack of evidence that the injured worker is recommended for specific dietary needs or distinctive nutritional requirements for a disease or condition. The provider's request does not indicate the dose or frequency of the medication in the request as submitted. As such, medical necessity has not been established.

Terocin Patch #20: 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.

Decision rationale: The request for Terocin Patch #20 is not medically necessary. The California MTUS Guidelines state topical compounds are largely experimental in use, with few randomized control trials to determine efficacy or safety, and are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended is not recommended. The guidelines state that capsaicin is recommended only as an option if injured workers are not responsive or intolerant to other treatments. The guidelines state that Lidoderm is the only topical form of Lidocaine approved. The included medical documents do not indicate that the injured worker has not responded, or is intolerant to, other treatments. The guidelines do not recommend any other formulation of topical Lidocaine in any other form than Lidoderm. Included medical documents lack evidence of an initial trial of antidepressants or anticonvulsants. The provider's request does not indicate the site that the cream is intended for, the frequency or the dose in the request as submitted. As such, medical necessity has not been established.

Retrospective Drug Screen (DOS 2/10/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids - On going Management.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Test Page(s): 43.

Decision rationale: The request for Retrospective Drug Screen (DOS 2/10/14) is not medically necessary. The California MTUS Guidelines recommend a urine drug test as an option to assess for the use or presence of illegal drugs. It may also be used in conjunction with a therapeutic trial of opioids, for allowing management and as a screening for risk of misuse and addiction. The documentation provided did not indicate the injured worker displayed any aberrant behaviors, drug seeking behavior, or whether the injured worker was suspected of illegal drug use. It is unclear when the last urine drug screen was performed. As such, medical necessity has not been established.