

<b>Case Number:</b>	CM14-0039338		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	04/09/1998
<b>Decision Date:</b>	12/18/2014	<b>UR Denial Date:</b>	03/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/03/2014

### 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, has a subspecialty in 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 63-year-old female who reported injury on 04/09/1998. The mechanism of injury was not submitted for review. The injured worker has a diagnosis of unspecified disc disorder of the cervical region. Past medical treatment consists of medication therapy. Medications consist of Motrin 800 mg and Fluriflex 180 g. Diagnostics consist of urine drug screens that were obtained on 12/13/2013 and 03/06/2004, showing that the injured worker was compliant with prescription medication. Report dated 12/23/2013 indicated that the injured worker had no prescribed medications. There were no subjective or objective findings documented on that report. Medical treatment plan is to continue with drug testing before prescribing opiate analgesics. The rationale and Request for Authorization form were not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective intramuscular injection of Vitamin B12 complex DOS 03/06/14: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (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, Vitamin B

**Decision rationale:** The request for retrospective IM injection of vitamin B12 is not medically necessary. The ODG does not recommend vitamin for the treatment of chronic pain. Vitamin B is frequently used for treating peripheral neuropathy, but its efficacy is not clear. A recent meta-analysis concluded that there are only limited data in randomized trials testing the efficacy of vitamin B for treating peripheral neuropathy and the evidence is insufficient to determine whether vitamin B is beneficial or harmful. The submitted documentation did not indicate the use of the vitamin B12. Additionally, there was no rationale submitted for review to warrant the retrospective IM of vitamin B12. Given that the ODG does not recommend the use of vitamin B as a treatment option and the lack of submitted documentation, the request for retrospective IM vitamin B12 is not medically necessary.

**Motrin 800mg #90 1 PO BID PRN with three (3) refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 22.

**Decision rationale:** The request for Motrin 800 mg is not medically necessary. The California MTUS Guidelines recommend anti-inflammatories as a traditional first line treatment, to reduce pain so activity and functional restoration can resume, but long term use may not be warranted. The submitted documentation did not indicate when or how long the injured worker had been on Motrin 800 mg. Additionally, the efficacy of the medication was not submitted for review, nor did it indicate that the Motrin was helping with any inflammation that the injured worker might be having. Furthermore, there was no assessment submitted for review indicating what the injured worker's pain levels were before, during and after medication administration. The documentation lacked any evidence whether the Motrin was helping the injured worker perform range of motion, motor exercises or helped with any sensory deficits. Additionally, guidelines recommend anti-inflammatories for a first line treatment, but do not recommend them for long term use. The documentation indicates that the injured worker's injury occurred in 1998. However, It is unclear as to how long the injured worker has been taking Motrin. Given the above, the injured worker is not within recommended guideline criteria. As such, the request is not medically necessary.

**Fluriflex 15/10% 180gm cream to apply a thin layer to affected area twice daily:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** The request for Fluriflex is not medically necessary. The California MTUS Guidelines state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily

recommended for neuropathic pain when trials of antidepressants or anticonvulsants have failed. Any compound product that contains at least 1 drug that is not recommended is not recommended. Topical NSAIDs are recommended for osteoarthritis and tendinitis, in particular that of the knee and elbow or other joints that are amenable to topical treatment. They are recommended for short term use, usually for 12 weeks. The submitted documentation lacked any indication of the injured worker having diagnoses congruent with guideline recommendations for topical NSAIDs. Additionally, the efficacy of the medication was not submitted for review, nor did it indicate that the Fluriflex was helping with any functional deficits the injured worker was having. Furthermore, the request as submitted did not indicate the site at which the cream was intended for or the frequency of the medication. Given the above, the injured worker is not within recommended guideline criteria. As such, the request is not medically necessary.

**Retrospective urinalysis DOS 03/06/14:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain

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

**Decision rationale:** The request for retrospective UA dated 03/06/2014 was not medically necessary. The California MTUS Guidelines recommend a urine drug test as an option to assess for the use or the presence of illegal drugs. They may also be used in conjunction with therapeutic trials of opioids, for ongoing management and as a screening for risk of misuse and addiction. It was submitted in the report that the injured worker had undergone a UA on 12/13/2013 and again on 03/06/2014. The results revealed that the injured worker was compliant with medications. However, it is unclear as to what the injured worker was being drug screened for. The submitted documentation indicated that the injured worker was not on any opioid or narcotic medications. There was also no evidence of the injured worker having or displaying any aberrant behaviors, drug seeking behavior or the use of illegal drugs. Given the above, the injured worker is not within recommended guideline criteria. Additionally, there was no rationale submitted for review to warrant the request for retrospective urinalysis. As such, the request is not medically necessary.