

Case Number:	CM14-0047239		
Date Assigned:	08/08/2014	Date of Injury:	06/18/2013
Decision Date:	09/15/2014	UR Denial Date:	03/17/2014
Priority:	Standard	Application Received:	04/15/2014

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 52-year-old female who reported an injury on 06/18/2013 due to a fall. The injured worker reportedly sustained an injury to her low back. The injured worker's treatment history included physical therapy, oral medications, and a subacromial injection to the shoulder. The injured worker's diagnoses included cervical disc protrusion, therapeutic sprain/strain, lumbar disc protrusion, lumbar spinal stenosis, lumbar facet syndrome, lumbar radiculopathy, left shoulder internal derangement, left shoulder tendonitis, left shoulder partial rotator cuff tear, and status post left shoulder injury. The injured worker was evaluated on 04/17/2014. The injured worker had limited range of motion of the cervical spine and bilateral shoulders with slight hypoesthesia of the left little finger. The injured worker also had limited range of motion of the lumbar spine with a positive straight leg raising test bilaterally. The injured worker's medications included cyclobenzaprine, Terocin patches, Norco 10/325 mg, Theramine, Sentra AM, Sentra PM, and Gabadone. The injured worker's treatment plan included refills of medications to assist with pain control and muscle spasming, acupuncture, and a urine drug screen. A Request for Authorization form to support the request was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine HCL 7.5.mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The requested Cyclobenzaprine HCL 7.5.mg #60 is not medically necessary or appropriate. The clinical documentation notes that the injured worker has been on this medication since at least 11/2013. California Medical Treatment Utilization Schedule does not support the use of muscle relaxants in the management of chronic pain. California Medical Treatment Utilization Schedule recommends that muscle relaxants be used for a short duration of treatment not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. As the injured worker has been on this medication for a duration to exceed guideline recommendations, further use would not be supported. Additionally, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Cyclobenzaprine HCL 7.5.mg #60 is not medically necessary or appropriate.

Norco 10/325 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management.

Decision rationale: The requested Norco 10/325 mg #60 is not medically necessary or appropriate. The clinical documentation indicates that the injured worker has been on this medication since at least 11/2013. California Medical Treatment Utilization Schedule recommends continued use of opioids in the management of chronic pain be supported by documented functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation does indicate that the injured worker is monitored for aberrant behavior with urine drug screens. However, the injured worker's evaluation on 02/18/2014 does not provide any evidence of pain relief or functional benefit resulting from the use of this medication. Therefore, continued use would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Norco 10/325 mg #60 is not medically necessary or appropriate.

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 (ODG), 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 chapter, Medical Food.

Decision rationale: The request for Sentra AM #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address medical food. Official Disability Guidelines do not recommend the use of medical food unless there is a specific dietary deficit that requires nutritional management. The clinical documentation submitted for review does not provide any evidence that the injured worker has any dietary or nutritional deficits that would benefit from the use of this medication. Furthermore, the request as it is submitted does not clearly identify a dosage or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Sentra AM #60 is not medically necessary or appropriate.

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 (ODG), 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 chapter, Medical Food.

Decision rationale: The request for Sentra PM #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address medical food. Official Disability Guidelines do not recommend the use of medical food unless there is a specific dietary deficit that requires nutritional management. The clinical documentation submitted for review does not provide any evidence that the injured worker has any dietary or nutritional deficits that would benefit from the use of this medication. Furthermore, the request as it is submitted does not clearly identify a dosage or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Sentra PM #60 is not medically necessary or appropriate.

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 (ODG), 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 chapter, Medical Food.

Decision rationale: The request for Gabadone #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address medical food. Official

Disability Guidelines do not recommend the use of medical food unless there is a specific dietary deficit that requires nutritional management. The clinical documentation submitted for review does not provide any evidence that the injured worker has any dietary or nutritional deficits that would benefit from the use of this medication. Furthermore, the request as it is submitted does not clearly identify a dosage or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Gabadone #60 is not medically necessary or appropriate.

Xolindo 2% Cream (Quantity not Specified): 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 requested Xolindo 2% Cream (Quantity not Specified) is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not support the use of lidocaine in a gel or cream formulation, as it is not FDA approved to treat neuropathic pain. The clinical documentation submitted for review does not provide any evidence to support extending treatment beyond guideline recommendations. As such, the requested Xolindo 2% Cream (Quantity not Specified) is not medically necessary or appropriate.

Mentoderm Gel 240 g #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 Salicylate topicals Page(s): 105.

Decision rationale: The requested Mentoderm Gel 240 g #1 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does support the use of salicylate topical agents. However, California Medical Treatment Utilization Schedule states that any medication used in the management of chronic pain be supported by documented functional benefit and evidence of pain relief. The clinical documentation fails to provide any evidence of functional benefit or pain relief resulting from the use of this medication. Therefore, continued use would not be supported. Additionally, the request as it is submitted does not provide a frequency of treatment or applicable body part. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Mentoderm Gel 240 g #1 is not medically necessary or appropriate.

Acupuncture Twice Weekly, Cervical and Lumbar Spine QTY: 8: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The requested Acupuncture Twice Weekly, Cervical and Lumbar Spine QTY: 8 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends ongoing acupuncture be supported by documented functional benefit, pain relief, and a reduction in medications. The clinical documentation submitted for review does indicate that the injured worker has previously participated in acupuncture. However, an adequate assessment of pain relief, quantitative measures to support functional improvement and a reduction in medications was not provided in association with prior therapy. As such, the requested Acupuncture Twice Weekly, Cervical and Lumbar Spine QTY: 8 is not medically necessary or appropriate.