MAXIMUS Federal Services

Case Number:	CM14-0059153		
Date Assigned:	08/08/2014	Date of Injury:	08/02/2001
Decision Date:	09/11/2014	UR Denial Date:	04/18/2014
Priority:	Standard	Application Received:	04/29/2014

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, has a subspecialty in Pain Management 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 patient with a date of injury of 8/2/01. A utilization review determination dated 4/18/14 recommends non-certification of Trepadone, Sonata, Prilosec, Ketoflex, Ativan, Sintralyne PM, Bionicare and knee braces, and urine drug screen. It referenced a 4/8/14 medical report identifying pain in the right thigh and knee. Bionicare stimulators with knee braces are helping with improvement. Inguinal nerve pain is coming back and the patient would like to be referred for another inguinal nerve block as he had 100% pain relief in the past. Pain is 3/10 with medication and 10/10 without. There were no significant findings on exam. Provider recommended UDS, Norco, Trepadone, Sonata, Prilosec, Ketoflex, Ativan, Sintralyne, and Bionicare and knee braces. 10/8/13 UDS was inconsistent as hydrocodone and lorazepam were listed as prescribed, but not detected. 10/29/13 UDS was inconsistent with marijuana detected, but not prescribed. Hydrocodone was detected on this test, but now listed as not prescribed. 12/10/13 UDS is inconsistent with marijuana detected, but not prescribed. Hydrocodone was listed as detected and prescribed. 1/14/14 UDS is inconsistent with lorazepam prescribed but not detected. Marijuana was detected, but not prescribed. 2/4/14 UDS is inconsistent with lorazepam prescribed, but not detected. 3/19/14 UDS is inconsistent with hydrocodone detected, but not noted as prescribed. 4/8/14 UDS is inconsistent with hydrocodone prescribed, but not detected. There are multiple medical reports noting the inconsistent UDS results and requesting ongoing use of UDS with no discussion regarding the inconsistent results or any apparent modifications to the treatment plan based on the results.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trepadone #120 x 2 Months: 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) - TWC Pain Procedure Summary last updated 04/10/2014.

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, Trepadone and Medical foods.

Decision rationale: Regarding the request for Trepadone, California MTUS does not address the issue. ODG cites that "There is no known medical need for choline supplementation except for the case of long-term parenteral nutrition or for individuals with choline deficiency secondary to liver deficiency." Additionally, "Glutamic Acid...is used for treatment of hypochlohydria and achlorhydria. Treatment indications include those for impaired intestinal permeability, short bowel syndrome, cancer and critical illnesses. It is generally used for digestive disorders in complementary medicine." Furthermore, "Gamma-aminobutyric acid (GABA)...is indicated for epilepsy, spasticity and tardive dyskenesia. There is no high quality peer-reviewed literature that suggests that GABA is indicated for treatment of insomnia." Also, regarding "L-Serine: There is no indication in Micromedix, Clinical Pharmacology, or AltMedDex the use of this product." Lastly, ODG notes that L-Arginine is not indicated in current references for pain or "inflammation." It is indicated to detoxify urine. Other indications include in use for angina, atherosclerosis, coronary artery disease, hypertension, migraines, obesity, and metabolic syndrome. These are the components of Trepadone and, as such, there is no clear indication for its use. In light of the above issues, the currently requested Trepadone is not medically necessary.

Sonata 10mg x 2 Months: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Moore & Jefferson: Handbook of Medical Psychiatry, 2nd ed., Mosby, Inc. Pp. 230, 460.

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, Insomnia treatment.

Decision rationale: Regarding the request for Sonata, California MTUS does not address the issue. ODG does support it as a first-line medication, but they note that short-term use (7-10 days) is indicated with a controlled trial showing effectiveness for up to 5 weeks. Within the documentation available for review, there is no clear indication of efficacy to date and the medication appears to be utilized for longer than the short-term treatment recommended by ODG. In light of the above issues, the currently requested Sonata is not medically necessary.

Prilosec 20mg x 2 Months: 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) - TWC Pain Procedures Summary last updated 04/10/2014, Proton Pump Mosby's Drug Consult.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): Page 68-69 of 127.

Decision rationale: Regarding the request for Prilosec, California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. In light of the above issues, the currently requested Prilosec is not medically necessary.

Ketoflex Ointment 240gm x 2 Months: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 111-113 of 127.

Decision rationale: Regarding the request for KetoFlex, California MTUS cites that topical Ketoprofen is "not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis." Muscle relaxants are not supported by the CA MTUS for topical use. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. In light of the above issues, the currently requested KetoFlex is not medically necessary.

Ativan 2mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009 Page(s): 24 OF 127.

Decision rationale: Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Within the documentation available for review, there is no documentation identifying any objective functional improvement as a result of the use of the Ativan and it appears that the medication is being prescribed for long-term use, which is not supported by the guidelines. In light of the above issues, the currently requested Ativan is not medically necessary.

Sintralyne PM #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) - TWC Pain Procedures Summary last updated 01/07/2014.

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, Melatonin and Medical food.

Decision rationale: Regarding the request for Sintralyne PM, which contains melatonin, gamma-aminobutyric acid, and "herbal complex no.183," California MTUS does not address the issue. ODG does provide some support for melatonin in the management of insomnia. They cite that "Gamma-aminobutyric acid (GABA)...is indicated for epilepsy, spasticity and tardive dyskenesia. There is no high quality peer-reviewed literature that suggests that GABA is indicated for treatment of insomnia." Within the documentation available for review, there is no rationale for the use of the GABA component of this compound in the management of the patient's cited conditions given the lack of support from ODG. In the absence of such documentation, the currently requested Sintralyne PM is not medically necessary.

Urine Drug Screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - TWC Pain Procedure Summary last updated 03/18/2014, Urine Drug Testing (UDT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 76-79 and 99 of 127.

Decision rationale: Regarding the request for a urine drug screen, CA MTUS Chronic Pain Medical Treatment Guidelines state the drug testing is recommended as an option. Guidelines go on to recommend monitoring for the occurrence of any potentially aberrant (or nonadherent) drug related behaviors. ODG recommends urine drug testing on a yearly basis for low risk patients, 2-3 times a year for moderate risk patients, and possibly once per month for high risk patients. Within the documentation available for review, there is documentation of approximately monthly urine drug screens, usually with inconsistent results. The corresponding medical reports mention the inconsistent results, but they do not contain any discussion regarding these inconsistencies, nor do they reflect any apparent changes in the treatment plan based on them. While inconsistent UDS results are consistent with a high-risk patient, there is no clear rationale for the ongoing use of frequent urine drug screens if the results do not prompt appropriate discussion and/or changes to the patient's medication management. In light of the above issues, the currently requested urine drug screen is not medically necessary.

Bionicare Knee Braces: 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) TWC Knee and Leg Procedure Summary last updated 03/31/2014, Bionicare Knee Device.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, Bionicare.

Decision rationale: Regarding the request for Bionicare knee braces, CA MTUS does not specifically address the issue. ODG recommends Bionicare as an option for patients in a therapeutic exercise program for osteoarthritis of the knee, who may be candidates for total knee arthroplasty but want to defer surgery. Within the documentation available for review, it is noted that the patient has knee osteoarthritis. However, as with any treatment, ongoing use is appropriate only in the presence of efficacy and continued need for the treatment. In this case, there is no clear indication of ongoing efficacy as evidenced by improved pain scores and more objective measures such as improvement in function and decreased pain medication usage from use of the devices. In the absence of such documentation, the current request for Bionicare knee braces is not medically necessary.