

Case Number:	CM14-0087925		
Date Assigned:	08/08/2014	Date of Injury:	11/27/2012
Decision Date:	09/17/2014	UR Denial Date:	05/20/2014
Priority:	Standard	Application Received:	06/11/2014

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 Texas and Oklahoma. 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 40-year-old male who reported an injury on 11/27/2012, after moving boxes up a stairway with a dolly. The injured worker reportedly sustained an injury to his low back and shoulder. The injured worker's treatment history included physical therapy, injections, surgery and multiple medications. The injured worker was evaluated on 01/06/2014. It was noted that the injured worker had neck pain radiating into the bilateral upper extremities described as 4/10 with low back pain radiating into the bilateral lower extremities rated at a 3/10. It was noted that the injured worker had undergone an epidural steroid injection on 12/27/2013 that provided significant relief. It was noted that the injured worker did not have any side effects with oral medications. Physical findings included restricted range of motion of the cervical spine secondary to pain, restricted range of motion of the right shoulder secondary to pain and restricted range of motion of the lumbar spine secondary to pain. The injured worker's diagnoses included neck sprain/strain, lumbar radiculitis, right shoulder full rotator cuff tear, left hip internal derangement and anxiety. The injured worker's treatment plan included an epidural steroid injection for the cervical spine, a qualitative drug screen, and continuation of medications to include Norco 10/325 mg, Lorazepam 1.0 mg, Theramine, Sentra AM, Sentra PM, Gabadone, Terocin patches, omeprazole and tramadol. A Request for Authorization dated 02/05/2014 for Gabadone, Sentra AM, Sentra PM and Theramine was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lorazepam 1.0 #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 23.

Decision rationale: The requested Lorazepam 1.0 #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends short durations of treatment for benzodiazepines due to the high risk of physical and psychological dependence. The clinical documentation does indicate that the injured worker has been using this medication for a significant duration of time. Therefore, ongoing use would not be supported. Additionally, 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 Lorazepam 1.0 #60 is not medically necessary or appropriate.

Genicin #90 (dosage not specified): Upheld

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

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 requested Genicin #90 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not specifically address medical food. Official Disability Guidelines state that medical food intended to manage disease or conditions that have distinctive nutritional requirements. The clinical documentation fails to provide any evidence that the injured worker has nutritional deficits that require dietary management. Furthermore, the request, as it is submitted, does not specifically identify a dosage or frequency. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Genicin #90 (dosage not specified) is not medically necessary or appropriate.

Somnicin #90 (dosage not specified): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 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 requested Somnicin #90 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not specifically address medical food.

Official Disability Guidelines state that medical food intended to manage disease or conditions that have distinctive nutritional requirements. The clinical documentation fails to provide any evidence that the injured worker has nutritional deficits that require dietary management. Furthermore, the request, as it is submitted, does not specifically identify a dosage or frequency. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Somnicin #90 (dosage not specified) is not medically necessary or appropriate.

Terocin Pain Patch #20: Upheld

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

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

Decision rationale: The requested Terocin pain patch #20 is not medically necessary or appropriate. The request medication is compounded topical agent that contains capsaicin, menthol, methyl salicylate and lidocaine. California Medical Treatment Utilization Schedule does not recommend the use of lidocaine in a patch form unless there is documentation that the injured worker has failed to respond to a course of oral anticonvulsants. The clinical documentation does not provide any evidence that the injured worker is unable to tolerate oral anticoagulants and requires lidocaine in a topical formulation. Additionally, California Medical Treatment Utilization Schedule does not support the use of capsaicin in a topical formulation unless there is documentation that the injured worker has not responded to first line chronic pain treatments. The clinical documentation does not indicate that the injured worker has failed to respond to anticoagulants or antidepressants. Therefore, the use of capsaicin in a topical formulation 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 Terocin pain patch #30 is not medically necessary or appropriate.

Terocin 120ml: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation California Medical Treatment Utilization Schedule (MTUS), 2009, American College of Occupational and Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines, Second Edition (2004), and Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2013.

Decision rationale: The requested Terocin 120 mL is not medically necessary or appropriate. Due to a lack of any type of description of this medication or its safety and benefits the

appropriateness of this medication could not be determined. As such, the requested Terocin 120 mL is not medically necessary or appropriate.

Flurbi(NAP) Cream LA 180gm: Upheld

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

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

Decision rationale: The requested Flurbi (NAP) cream LA 180 gm is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not support the use of Flurbiprofen as a topical analgesic unless there is documentation that the injured worker has failed to respond to or cannot tolerate oral formulations of non-steroidal anti-inflammatory drugs. Furthermore, California Medical Treatment Utilization Schedule does not recommend the use of non-steroidal anti-inflammatory drugs for injuries involving the spine or shoulder. Furthermore, the request, as it is submitted does not clearly identify a frequency or applicable body part. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Flurbi (NAP) cream LA 180 gm is not medically necessary or appropriate.

Physical Therapy 3 times a week for 4 weeks to cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The requested physical therapy 3 times a week for 4 weeks to the cervical spine is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends up to 10 visits for radicular and myofascial pain. The requested 12 visits exceed this recommendation. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. Additionally, California Medical Treatment Utilization Schedule recommends that injured workers be transitioned to a home exercise program to maintain improvement levels obtained during skilled physical therapy. There is no documentation that the injured worker is participating in the home exercise program and requires additional supervision provided by physical therapy. As such, the requested physical therapy 3 times a week for 4 weeks to the cervical spine is not medically necessary or appropriate.

Gabacyclotram 180mg: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Effectiveness of topical administration of opioids in palliative care: a systematic review; B LeBon, G Zeppetella, IJ Higginson - Journal of pain and symptoms,2009 - Elsevier.

Decision rationale: The requested Gabaclotram 180 mg is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not support the use of gabapentin or cyclobenzaprine as topical agents as there is little scientific evidence to support the efficacy and safety for the use of these medications in a topical formulation. California Medical Treatment Utilization Schedule and Official Disability Guidelines do not address opioid usage in a topical formulation. Peer reviewed literature, however, does not support the use of opioids in a topical formulation as there is little scientific evidence to support the efficacy and safety of the use of these types of medications. Furthermore, 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 Gabaclotram 180 mg is not medically necessary or appropriate.