

Case Number:	CM14-0098511		
Date Assigned:	07/28/2014	Date of Injury:	07/08/2013
Decision Date:	10/28/2014	UR Denial Date:	06/04/2014
Priority:	Standard	Application Received:	06/26/2014

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 Occupational 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 51-year-old female who sustained injuries to her neck, shoulders, and low back on July 8, 2013. On December 18, 2013, a drug compliance and diversion screen was conducted. Laboratory testing showed positive for of opiate Hydrocodone, which was consistent with prescribed medication. Additional medications detected not reported as prescribed include Cyclobenzaprine, Tramadol, Venlafaxine/Desvenlafaxine, which was inconsistent with prescription therapy. Repeat urine drug screen on January 15, 2014 showed positive Cyclobenzaprine consistent with prescription therapy. However, there was inconsistency with prescribed Hydrocodone as it was not detected. The injured worker was evaluated on January 24, 2014 with complaints of pain in her neck, back, and left shoulder. Physical examination was deferred due to painful condition. She was re-examined on March 12, 2014 with complaints of constant neck and low back pain that radiated to her left upper extremity and lower extremities with associated numbness and tingling with pain level of 4/10 and 6/10 as well as constant left shoulder pain with intensity of 7/10. Physical examination revealed restricted ranges of motion of the cervical, thoracic and lumbar spine, as well as her left shoulder. Urine drug testing obtained on the same date had detected inconsistency due to presence of Cyclobenzaprine and Tramadol, which were not reported as prescribed. On the other hand, prescribed Hydrocodone was positive. Repeat urine drug testing on April 16, 2014 showed inconsistent findings. Tramadol, which was not prescribed, was positive while the prescribed Hydrocodone was negative. The injured worker followed-up on May 9, 2014 and rated her neck and back pain that radiated to her upper and lower extremities with intensity of 5-6/10 and her left shoulder with pain level of 7/10. She reported that her oral pain medications decreased her pain from 6-9/10 to 0-1/10. She also noted that her topical medications decreased her pain, enabled her to walk and sit longer, increased sleep and chores performance, and decreased her use of oral medications.

She also specified that lumbar epidural injection had provided her with 90 percent benefit and prior cervical epidural injection had provided her with 80 percent benefit. Objective findings revealed restricted ranges of motion of the cervical spine, left shoulder, and lumbar spine. Cervical and lumbar spine spasms were also noted. Diminished sensation was noted along C6-C7. The injured worker was seen on May 13, 2014 for qualified medical evaluation. Her medications include Norco, Ibuprofen, Flexeril, and topical ointment. Physical examination of the cervical and lumbar spine revealed tenderness with spasm over the paravertebral and trapezial musculature and limited ranges of motion. Neurological examination revealed diminished sensation along the lateral left calf. Examination of the left shoulder showed tenderness over the biceps tendon and decreased range of motion. Left elbow examination demonstrated tenderness over the dorsal forearm musculature. Left wrist examination revealed tenderness over the dorsal aspect of the wrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

Menthoderm Gel 240gm: 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): 111-113.

Decision rationale: There was no indication that the injured worker is intolerant to oral antidepressants and anticonvulsants to necessitate use of topical agents. The Chronic Pain Medical Treatment Guidelines state that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Therefore, the request is not medically necessary.

Urine Drug Screen: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing; Opioids, specific drug list Page(s): 43;94. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Opioids, tools for risk stratification & monitoring and Urine Drug Testing (UDT)

Decision rationale: The injured worker tested positive for non-prescribed drugs; as such, frequent urine drug testing is necessary to monitor the injured worker. The Official Disability Guidelines specifies that workers at high risk of adverse outcomes may require testing as often as once per month. The reviewing physician specified that there was no indication to do urine drug screening with the frequency as the treating physician was doing based on the information provided. Progress reports of the treating physician's specified that qualitative drug screen was

administered to evaluate ongoing medication therapy and to determine consistent medication management. Therefore, the request is medically necessary.

6 Physical Therapy Visits for Cervical and Lumbar: Upheld

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

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

Decision rationale: By this time, the injured worker is expected to be active with self-directed home exercises. The injured worker did not suffer from recent flare-up and there was no rationale provided as to why treatment goals cannot be accomplished with independent home exercise program versus supervised physical therapy. The Official Disability Guidelines states that without proper worker selection, routine physical therapy may be no more effective than one session of assessment and advice from a physical therapist. Therefore, the request is not medically necessary.

1 year Gym Membership: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar & Thoracic (Acute & Chronic), Gym Memberships

Decision rationale: There was no indication that advanced specialized equipment is needed and that individual self-directed home exercise program is not effective to necessitate health club membership. According to the Official Disability Guidelines, gym membership is not recommended unless a documented home exercise program with periodic assessment and revision has not been effective and there is a need for equipment. Therefore, the request is not medically necessary.

6 Chiropractic Visits for Cervical and Lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines-Chronic Pain, Neck & Upper Back, Lower Back

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

Decision rationale: There was no documentation describing whether or not prior chiropractic care had been rendered and if so, was there any objective functional improvement. Furthermore, there was no indication that the injured worker has had recent flare-up of her pain and for which active involvement in home exercise program had failed. The Chronic Pain Medical Treatment Guidelines state that elective/maintenance care of manual therapy and manipulation is not medically necessary and that for recurrences/flare-ups; treatment success needs to be reevaluated. Therefore, the request is not medically necessary.

Cervical Epidural Steroid Injection (CESI) at C6-C7: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: Prior to considering repeat epidural injection, evidence that exhaustion of conservative treatment had failed is warranted. Moreover, physical examination findings are not consistent with active radiculopathy and were not correlated by imaging studies. The Chronic Pain Medical Treatment Guidelines states that the criteria for epidural steroid injection include (a) radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing; (b) initially unresponsive to conservative treatment. Therefore, the request is not medically necessary.

Gabadone #60: 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 (Chronic), Medical Food

Decision rationale: There was no evidence that the injured worker needs alternative supplemental treatment in the form of Gabadone. Moreover, this medical food has no conclusive evidence to support its use. The Official Disability Guidelines states that medical food is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation. Therefore, the request is not medically necessary.

Theramine #90: 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 (Chronic), Medical Food and Theramine

Decision rationale: There was no evidence that the injured worker needs alternative supplemental treatment in the form of Theramine. Moreover, this medical food has no conclusive evidence to support its use. The Official Disability Guidelines states that medical food is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation. Furthermore, the Official Disability Guidelines specifies that Theramine is not a recommended medical food. Therefore, the request is not medically necessary.

Trepadone #90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic Pain 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 (Chronic), Medical Food.

Decision rationale: There was no evidence that the injured worker needs alternative supplemental treatment in the form of Trepadone. Moreover, this medical food has no conclusive evidence to support its use. The Official Disability Guidelines states that medical food is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation. Therefore, the request is not medically necessary.

Sentra AM #60: 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 Non-MTUS Official Disability Guidelines (ODG) Pain (Chronic), Medical Food.

Decision rationale: There was no evidence that the injured worker needs alternative supplemental treatment in the form of Sentra AM. Moreover, this medical food has no conclusive evidence to support its use. The Official Disability Guidelines states that medical food is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation. Furthermore, the Official Disability Guidelines specifies that Sentra is not a recommended medical food. Therefore, the request is not medically necessary. .

Xolido 2% Cream: 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): 111-113.

Decision rationale: There was no indication that the injured worker is intolerant to oral antidepressants and anticonvulsants to necessitate use of topical agents. The Chronic Pain Medical Treatment Guidelines state that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Moreover, Xolido, which is a Lidocaine Hydrochloride cream, is not supported by the guidelines. The Chronic Pain Medical Treatment Guidelines specifies that there is no other commercially approved topical formulation of lidocaine, (whether creams, lotions or gels) that is indicated for neuropathic pain. Therefore, the request is not medically necessary.