MAXIMUS Federal Services

Case Number:	CM14-0011670		
Date Assigned:	02/21/2014	Date of Injury:	10/22/2010
Decision Date:	11/12/2015	UR Denial Date:	12/31/2013
Priority:	Standard	Application Received:	01/29/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: New York
Certification(s)/Specialty: Pediatrics, Internal Medicine

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 injured worker is a 51-year-old female who reported an industrial injury on 10-22-2010. Her diagnoses, and or impressions, were noted to include brachial neuritis or radiculitis; lumbar spinal stenosis; right carpal tunnel syndrome; and left knee lateral meniscus tear. Urine toxicology screenings were noted on 5-25-2013, 8-20-2013, 9-19-2013, & 10-17-2013. Magnetic imaging studies of the right knee were noted on 12-10-2013. Her treatments were noted to include orthopedic consultation and treatment; Toradol injection therapy (9-19-13); physical therapy; an agreed medical-legal examination on 12-13-2013; medication management with toxicology screenings; and rest from work. The progress notes of 6-13-2013 reported constant, moderate-severe neck pain; constant, and severe low back pain that radiated to the lower extremities and left knee, with numbness and tingling. Objective findings were noted to include the inability to perform a left straight leg raise test due to pain; and 0 extension of the left knee. The physician's requests for treatments were noted to include: multiple pain management follow-up visits; drug screening; multiple acupuncture treatments for pain control; multiple chiropractic treatments and modalities; magnetic imaging (MRI) studies of the right knee; chiropractic and acupuncture treatments; and the continuation of Norco, Valium, Xanax, Gabapentin, Cyclobenzaprine Hydrochloride, Omeprazole, Theramine, Sentra AM & PM, GABAdone, Terocin Pain Patches, topical compound creams (initiated 8-15-2013), and Synthroid; and the an orthopedic evaluation for the right knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

Follow up evaluation every 4-6 weeks with pain management: 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), Low Back Chapter, Office Visits.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Chronic pain programs (functional restoration programs).

Decision rationale: Indications for referral to pain management include all of the following: (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed. The documentation provided did not note any of the indications for pain management referral. This request is not medically necessary and appropriate.

Acupuncture for pain control in the cervical and lumbar spine, bilateral knees and right wrist - 2 times a week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: Acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm, ODG guidelines recommended as an option for chronic low back pain using a short course of treatment in conjunction with other interventions. Acupuncture for the knee is recommended as an option for osteoarthritis, but benefits are limited. Carpal tunnel guidelines state that acupuncture is not recommended. As the request was for acupuncture for all sites and there is lack of documentation that the IW was in rehabilitation or weaning and not tolerating pain medications this request is deemed to be not medically necessary.

Chiropractic manipulation and appropriate ancillary procedures for the cervical and lumbar spine, bilateral knees and right wrist - 2 times a week for 3 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: Per MTUS and ODG guidelines, chiropractic manipulation is recommended as an option for chronic pain if caused by musculoskeletal conditions. Medical evidence shows good outcomes from the use of manipulation in acute low back pain without radiculopathy (but also not necessarily any better than outcomes from other recommended treatments). For patients with chronic low back pain, manipulation may be safe and outcomes may be good, but the studies are not quite as convincing. If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated. Chiropractic manipulation for carpal tunnel syndrome and for knee disorders is not recommended. The request is not medically necessary and appropriate.

Norco 10/325mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: The IW is documented to be on a combination opioid for pain relief. Documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Additionally, this is redundant therapy as the IW is already on Norco. This request is not medically necessary.

Valium 10mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

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. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance

to hypnotic effects develops rapidly. 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. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. Additionally, there is no note of the IW's anxiety or pain from muscle spasm and response to the medication, which is required to prove medical necessity. This request is not medically necessary and appropriate.

Xanax 1mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

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. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. 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. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. Additionally, there is no note of the IW's anxiety or response to the medication, which is required to prove medical necessity. This request is not medically necessary and appropriate.

Gabapentin 600mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: MTUS guidelines state that antiepileptic drugs are recommended for neuropathic pain. A good response to the use of AEDs has been defined as a 50% reduction in pain and a moderate response as a 30% reduction. The patient should be asked at each visit as to whether there has been a change in pain or function. It is noted that there is no EMG/NCV in the case file to document neuropathy in the IW and there is not consistent finding on physical exam that would correlate with neuropathy. There was no documentation of objective functional benefit with prior use of this medication. The request is not medically necessary and appropriate

Cyclobenzaprine Hydrochloride 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: MTUS recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. It is noted that in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. In addition, there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. The documentation does reference muscle spasm that the Flexeril would be used for however at this time frame it is not indicated. The request is not medically necessary and appropriate.

Omeprazole 20mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.accessdata.fda.gov/drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: According to MTUS guidelines, it is necessary to determine if the patient is at risk for gastrointestinal events. Risk factors are: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). A history of ulcer complications is the most important predictor of future ulcer complications associated with NSAID use. There was no notation of GI symptoms or a history of risk factors nor was the IW taking any NSAIDs. This request is not medically necessary or appropriate.

Theramine: 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 food section.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Medications - Medical Food.

Decision rationale: MTUS guidelines do not comment on the use of Theramine. ODG states that Theramine is not recommended for the treatment of chronic pain. See Medical food. Under this entry discussions of the various components of this product are given. The entries for 5-hydroxytryptophan, choline bitartrate, L-arginine, Histidine, L-glutamine, L-serine and GABA are given and all indicate that there is no role for these supplements as treatment for chronic pain. This request is not medically necessary and 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 food secion.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Medications - Medical Food.

Decision rationale: MTUS guidelines do not comment on the use of Sentra. ODG states that Sentra is not recommended. Sentra AM is a medical food from [redacted], [redacted], intended for use in management of fatigue and cognitive disorders. It is a proprietary blend of Choline Bitartrate, Cocoa Extract, L-Glutamic Acid, Acetyl L-Carnitine, Dextrose, Ginkgo Biloba, and Hawthorn Berry. See Medical food, Choline & Glutamic Acid. This request is not medically necessary and 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 food section.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Medications - Medical Food.

Decision rationale: MTUS guidelines do not comment on the use of Sentra. ODG states that Sentra is not recommended. Sentra PM is intended for use in management of sleep disorders associated with depression. Sentra PM is a proprietary blend of neurotransmitter precursors (choline bitartrate, glutamate, and 5-hydroxytryptophan); polyphenol antioxidants (hawthorn berry, cocoa); an amino acid uptake stimulator (gingko biloba); activators of amino acid utilization (acetyl-L-carnitine, glutamate, cocoa powder); and an adenosine antagonist (cocoa powder). Choline is a precursor of acetylcholine. 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. This is a precursor of gamma-aminobutyric acid (GABA).This supplement is used for treatment of gastric hydrochloric acid deficiency. This is the intermediate metabolite between biosynthesis of L-tryptophan to serotonin. In alternative medicine, it has been used for insomnia, obesity, aggressive behavior, eating disorders, fibromyalgia, chronic headaches and various pain disorders (postulated to inhibit inflammation). Current peer-reviewed evidence is inconclusive to support these claims. This request is not medically necessary and 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Medications - Medical Food.

Decision rationale: MTUS guidelines do not comment on the use of GABAdone. ODG states that GABAdone is not recommended. GABAdone is a Medical food from [redacted], that is a proprietary blend of choline bitartrate, glutamic acid, 5-hydroxytryptophan, GABA, grape seed extract, griffonia extract, whey protein, valerian extract, ginkgo biloba and cocoa. It is intended to meet the nutritional requirements for sleep disorders and sleep disorders associated with insomnia. This request is not medically necessary and appropriate.

Terocin pain patch box (10 patches) #2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: MTUS guidelines state that lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy. Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Even though menthol is approved for topical use this cannot be approved due to other components not being medically necessary. This request is not medically appropriate and reasonable.

MRI of the right knee: Overturned

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) knee – MRI's (magnetic resonance imaging).

Decision rationale: According to ODG guidelines, MRI's (magnetic resonance imaging) are recommended as indicated below. For acute trauma to the knee, including significant trauma (e.g., motor vehicle accident), or if suspect posterior knee dislocation or ligament or cartilage disruption. According to ACOEM guidelines, reliance only on imaging studies to evaluate the source of knee symptoms may carry a significant risk of diagnostic confusion (false-positive test results) because of the possibility of identifying a problem that was present before symptoms began, and therefore has no temporal association with the current symptoms. Even so, remember that while experienced examiners usually can diagnose an ACL tear in the nonacute stage based on history and physical examination, these injuries are commonly missed or over diagnosed by inexperienced examiners, making MRIs valuable in such cases. The request is medically necessary and appropriate.