

Case Number:	CM15-0009746		
Date Assigned:	01/27/2015	Date of Injury:	02/16/2007
Decision Date:	03/26/2015	UR Denial Date:	12/29/2014
Priority:	Standard	Application Received:	01/16/2015

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: Emergency 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:

The injured worker (IW)) is a 62 year old male, who sustained a work related injury on 5/12/06. The diagnoses included cervical sprain, cervical spinal cord syrinx, carpal tunnel syndrome, degenerative disk disease, status post lumbar decompression, Charcot-Marie-Tooth disease, and right shoulder strain. Treatments have included oral pain medication, lumbar decompression, radiofrequency neurotomy of right 3rd occipital nerve and C3 deep medial branch nerve, cervical spine surgery and trigger point injections. A provider note dated 12/16/2014 documents the IW complains of neck, upper and lower back pain and suboccipital headaches. He complains of muscle spasms in neck and upper back. He rates all the pain a 5-8/10 and has been increasing his medication use for pain control. Physical examination revealed decreased range of motion in neck, upper and lower back. There was tenderness to touch in the neck, upper and lower back to palpation. His work status was not documented. On 12/29/2014, Utilization Review denied a request for Clonazepam, Pantoprazole, Tamiflu, Voltarn Gel, Xopenex, Androgel, Metanx, and Trigger point injections. UR approved a request for gabapentin. Ca MTUS Treatment Guidelines and ODG guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Clonazepam: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: Ca MTUS guidelines state that benzodiazepines are "not recommended for long term use because long term efficacy is unproven and there is a risk of dependence." Furthermore, guidelines limited treatment duration to 4 weeks. Records support the IW has been taking clonazepam for a minimum of 4 months. This clearly exceeds the recommended term of use and is not within CA MTUS guideline. The request is not medically necessary.

Pantoprazole: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: According to CA MTUS, gastrointestinal protectant agents are recommended for patients that are at increased risk for gastrointestinal events. These risks include age >65, history or gastrointestinal bleeding or peptic ulcers, concomitant use of NSAIDs and corticosteroids or aspirin, or high dose NSAID use. The chart does not document any of these risk factors. Past medical history does not include any gastrointestinal disorders, there is no history of poor tolerance to NSAIDs documented and there are not abdominal examinations noted in the chart. Ranitidine is not medically necessary based on the MTUS.

Tamiflu: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation
<<http://www.guideline.gov/content.aspx?id=25627&search=tamiflu>>

Decision rationale: CA MTUS and ODG are silent. The above listed reference provides the following recommendations for the prevention and control of influenza.-Antiviral treatment is recommended as soon as possible for patients with confirmed or suspected influenza who have severe, complicated, or progressive illness or who require hospitalization.-Antiviral treatment is recommended as soon as possible for outpatients with confirmed or suspected influenza who are at higher risk for influenza complications on the basis of their age or underlying medical conditions; clinical judgment should be an important component of outpatient treatment decisions.-Recommended antiviral medications include oseltamivir and zanamivir, on the basis

of recent viral surveillance and resistance data indicating that >99% of currently circulating influenza virus strains are sensitive to these medications. Amantadine and rimantadine should not be used because of the high levels of resistance to these drugs among circulating influenza A viruses, but information about these drugs is provided for use if current recommendations change because of the reemergence of adamantane-susceptible strains. -Oseltamivir may be used for treatment or chemoprophylaxis of influenza among infants aged <1 year when indicated.- Antiviral treatment also may be considered on the basis of clinical judgment for any outpatient with confirmed or suspected influenza who does not have known risk factors for severe illness if treatment can be initiated within 48 hours of illness onset.-Because antiviral resistance patterns can change over time, clinicians should monitor local antiviral resistance surveillance data. The antiviral medications are prescribed within 48 hours of the onset of symptoms. The IW does not have any respiratory or immunocompromised conditions that make him at an elevated susceptibility to influenza. As there is 2 day timeframe in which the IW could get this medication, a prescription to enable the medication to be available on hand is not indicated. The request for Tamiflu is not medically necessary.

Voltaren Gel: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: Voltaren is a non-steroidal anti-inflammatory agent. CA MTUS guidelines state that topical NSAIDs have been shown to have efficacy in the first 2 weeks of osteoarthritis, but afterwards efficacy diminishes. Voltaren Gel is "indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee and wrist.) It has not been evaluated for treatment of spine, hip, or shoulder." The IW has been receiving this medication for a minimum of 4 months. The request does not include dosing, point of application, or frequency. The request for Voltaren Gel is not medically necessary.

Xopenex: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation
<<http://www.nlm.nih.gov/medlineplus/druginfo/meds/a603025.html>>

Decision rationale: CA MTUS and ODG are silent. Xopenex is a lung modulating medication used in the treatment and prevention of wheezing, shortness of breath, and cough caused by chronic lung disease including emphysema, bronchitis and asthma. The IW does not have documented any of these diagnoses. There is no documentation of pulmonary evaluations,

physical exam or function testing. There is no documentation that the IW has used this medication or any effects of its use. The request for xoponex is not medically necessary.

Androgel: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Guidelines- Testosterone Replacement Therapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain. Testosterone replacement for hypogonadism (related to opioids)

Decision rationale: CA MTUS is silent on this topic. ODG guidelines recommend testosterone replacement be used in "limited circumstances for patients taking high-dose long-term opioids with documented low testosterone levels." Submitted documentation does not include laboratory studies or discussion of testing results to support the diagnosis of testosterone deficiency. Without this, guidelines are not satisfied. The request is not medically necessary.

Metanx: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medical Foods - ODG Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain - Medical Food

Decision rationale: Metanx is a medical food that is reported to aid in the dietary management of blood flow in vessels. CA MTUS is silent on this topic. ODG guidelines state medical food is not recommended for chronic pain as "they have not been shown to produce meaningful benefits or improvements in functional outcomes." ODG further states "there are no quality studies demonstrating the benefit of medical foods in the treatment of chronic pain." As such, the request for Metanx is not medically necessary.

Trigger point injections: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 122.

Decision rationale: CA MTUS recommends trigger point injections for myofascial pain syndrome only and not for radicular pain. Trigger points are focal areas of tenderness that produce a local twitch in response to stimulus to the area. The IW has previously had trigger point injections with report of symptom relief. The submitted material does not support a local

twitch response when stimulated. Without this documentation, the request for trigger point injections are not medically necessary.