

Case Number:	CM15-0193469		
Date Assigned:	10/07/2015	Date of Injury:	06/26/2003
Decision Date:	12/16/2015	UR Denial Date:	09/02/2015
Priority:	Standard	Application Received:	10/01/2015

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: Tennessee, Florida, Ohio
 Certification(s)/Specialty: Surgery, Surgical Critical Care

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 46 year old male who sustained an industrial injury on 06-26-2003. Medical records indicated the worker was treated for chronic low back pain with symptoms into the right lower extremity. In the provider notes of 08-13-2015, the injured worker complains of low back pain radiating occasionally to the buttocks, and into the right posterior lateral thigh and into the right big toe. He complains of pain and occasional numbness and tingling in the low back. He also gets numbness and weakness in the right lower extremity. On exam, there is mildly increased thoracic kyphosis with the left shoulder being slightly higher. There is pain in the right calf with tiptoe-heel walking. There is pain in the lumbar spine with an incomplete squat. There is a 5 cm vertical scar on the lower midline lumbar spine. Straight leg raising is positive on the right. There is crepitation in the left knee on range of motion and there is a 7 cm non -surgical scar on the medial suprapatellar area of the left knee. The worker is status post right L5-S1 hemilaminectomy and discectomy with MRI evidence (04-21-2010) of a 7mm right L5-S1 recurrent or residual disc herniation. The worker is diagnosed also with depressed mood, anxiety disorder not otherwise specified. Treatment rendered included a physical exam, x-rays of the lumbar spine, medications, continuation of use of a tens unit, a urine drug screen, and a lumbar support were ordered. A request for authorization was submitted for: (1). Unknown Flurbiprofen cream (2). One month use of a home based neurostimulator (TENS-EMS) with supplies (3). Prilosec 20mg, #60 (4). Theramine #90 (5). One urine drug screen (6). One X-ray of the lumbar spine (7). One lumbar spine support. A utilization review decision 09-02-2015. Non- certified: Flurbiprofen cream; One month use of a home based neurostimulator (TENS-EMS) with supplies; Theramine #90; One urine drug screen; One X-ray of the lumbar spine; Prilosec 20mg, #60 Certified; One lumbar spine support.

IMR ISSUES, DECISIONS AND RATIONALES

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

Unknown Flurbiprofen cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. Per the California MTUS guidelines, topical NSAIDs are only recommended for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment." They should only be use for Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Use for neuropathic pain is not recommended as there is no evidence to support use. Furthermore, the dose and quantity of the medication is not documented on the prescription provided for this patient. MTUS guidelines state that prescriptions must contain clear dosage and use instructions with a set quantity for use. Therefore, based on the submitted medical documentation, the request for flurbiprofen cream is not medically necessary.

One month use of a home based neurostimulator (TENS-EMS) with supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

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

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of a TENS unit for this patient. The California MTUS guidelines recommend the following regarding criteria for TENS unit use: (1). Chronic intractable pain (for the conditions noted above): Documentation of pain of at least three months duration. (2). There is evidence that other appropriate pain modalities have been tried (including medication) and failed; A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial (3). Other ongoing pain treatment should also be documented during the trial period including medication usage. (4). A treatment plan including the specific short- and long- term goals of treatment with the TENS unit should be submitted (5). A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. This patient's case does not meet the recommended criteria since no treatment plan (that includes short and long term goals) was submitted. There is also no clear

documentation that other treatment modalities have been tried and failed without functional improvement. Therefore, based on the submitted medical documentation, the request for TENs unit is not medically necessary.

Prilosec 20mg, #60: Upheld

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

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

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of the requested prescription for this patient. The clinical records submitted do not support the fact that this patient has refractory GERD resistant to H2 blocker therapy or an active h. pylori infection. The California MTUS guidelines address the topic of proton pump prescription. In accordance with California MTUS guidelines, PPI's (Proton Pump Inhibitors) can be utilized if the patient is concomitantly on NSAIDs and if the patient has gastrointestinal risk factors. This patient is not on NSAIDs. Additionally, per the Federal Drug Administration's (FDA) prescribing guidelines for PPI use, chronic use of a proton pump inhibitor is not recommended due to the risk of developing atrophic gastritis. Short-term GERD symptoms may be controlled effectively with an H2 blocker unless a specific indication for a proton pump inhibitor exists. This patient's medical records do not support that this patient has GERD. Furthermore, the patient has no other documentation of why chronic PPI therapy is necessary, including the fact that he does not have GERD documented to be refractory to H2 blocker therapy and he has not records that indicate an active h. pylori infection. Therefore, based on the submitted medical documentation, the request for Prilosec prescription is not medically necessary.

Theramine #90: 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), Pain (Chronic): Theramine (2015).

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 foods; Theramine.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this medication for this patient. The California MTUS guidelines and the ACOEM Guidelines do not address this topic. According to the Official Disability Guidelines (ODG), Theramine is: "Not recommended for the treatment of chronic pain. Theramine is a medical food that contains 5-hydroxytryptophan 95%, choline bitartrate, L-arginine, histidine, L-glutamine, L-serine, gamma-aminobutyric acid (GABA), whey protein concentrates, grape seed extract 85%, cinnamon, and cocoa (theobromine 6%)." This patient has chronic lower back pain secondary to an industrial accident. Per ODG, theramine is specifically not indicated for the

treatment of chronic pain. Therefore, based on the submitted medical documentation, the request for Theramine is not medically necessary.

One urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, steps to avoid misuse/addiction. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (chronic): Urine drug testing (UDT) (2015).

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

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of a urine drug screen for this patient. The clinical records submitted do not support the fact that this patient has been documented to have a positive drug screen for illicit or non-prescribed substances. The MTUS guidelines recommend frequent and random urine drug screens where aberrant behavior is suspected. This patient has not been documented to have suspicion of aberrant behavior. His pain is documented as well controlled and past drug screens are consistent with currently prescribed medications. Therefore, based on the submitted medical documentation, the request for drug screening is not medically necessary.

One X-ray of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back- Lumbar & Thoracic (Acute & Chronic): Radiography (x-rays) 2015.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Diagnostic Criteria, Initial Care, Special Studies.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. X-ray of the lumbar spine is not medically necessary per the MTUS ACOEM Guidelines. The MTUS guidelines state that lumbar spine x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. The medical documentation supports that this patient does not have any red flag symptomatology. He has had chronic pain for more than a year with prior imaging non-diagnostic for a cause of this patient's chronic pain. Per MTUS, an x-ray for the lumbar spine is not indicated. Therefore, based on the submitted medical documentation, the request for lumbar spine x-ray is not medically necessary.