

Case Number:	CM15-0049840		
Date Assigned:	04/09/2015	Date of Injury:	08/30/2012
Decision Date:	08/03/2015	UR Denial Date:	02/20/2015
Priority:	Standard	Application Received:	03/16/2015

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: 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:

The injured worker is a 51 year old male, who sustained an industrial injury on 8/3/12. He reported initial complaints of back pain with radiating pain down left leg. The injured worker was diagnosed as having lumbar vertebral disc without myelopathy; psych; insomnia; cervical sprain/strain; shoulder sprain/strain. Treatment to date has included selective nerve root block left L4 and L5 (10/28/14 and 2/10/15); medications. Diagnostics include MRI lumbar spine (8/6/12); EMG/NCV lower extremities (2/27/14). Currently, the PR-2 notes dated 2/10/15 indicate the injured worker complains of low back pain that is constant and radiates into the left lower extremity associated with tingling, numbness, weakness, status post work injury. He rates the pain at 4/10 and aggravated by prolonged sitting, standing, coughing, sneezing, somewhat improves with medications, lying down. He describes the pain as shooting, stabbing, aching, throbbing, cramping pain. The injured worker has tingling, numbness, left leg muscle spasms, lower back muscle weakness and left lower extremity weakness. The pain is affecting his sleep which is causing emotional, financial, marital and work disturbances. The injured worker's treatment included a selective nerve root block left L4 and L5 (10/28/14) which gave him back and left lower extremity relief of pain for about six hours. On 2/10/15 another procedure L4 selective nerve root block to confirm the pain generator at L4-L5. He continues to remain 40% improved back pain and radiating left leg pain. The provider is requesting Urinalysis for Toxicology, Pain Management Referral, Psyche Bio Behavioral Pain Management, Flurbiprofen/Capsaicin/Camphor 10/0.025%, 2%, 1% 120gm, Ketoprofen/Cyclobenzaprine/

Lidocaine 10%, 3%, 5% 120gm, Theramine #90, Sentra AM #60, Flexeril/Cyclobenzaprine 7.5mg #60, Ultracet/Tramadol ER 150mg #60, Gabadone #60, Sudo Scan, and Autonomic Nervous Study.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urinalysis for Toxicology: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Criteria for use of Urine Drug Screen.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, differentiation: dependence & addiction Page(s): 85. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids, Urine drug tests.

Decision rationale: MTUS recommends screening patients to differentiate between dependence and addiction to opioids. Frequency of urine drug testing should be based on documented evidence of risk stratification. Patients at "low risk" of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. Random collection is recommended. Quantitative urine drug testing is not recommended for verifying compliance without evidence of necessity. Documentation does not show that the injured worker is being treated with a medication that warrants urine drug testing or at high risk of addiction or aberrant behavior. With guidelines not being met, the request for Urinalysis for Toxicology is not medically necessary.

Pain Management Referral: 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 Chronic pain programs (functional restoration programs) Page(s): 30-33, 49.

Decision rationale: Multidisciplinary pain programs or Interdisciplinary rehabilitation programs combine multiple treatments, including physical treatment, medical care and supervision, psychological and behavioral care, psychosocial care, vocational rehabilitation and training and education. Per MTUS guidelines, Outpatient pain rehabilitation programs may be recommended if previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement, if the patient has a significant loss of ability to function independently resulting from the chronic pain and if the patient is not a candidate where surgery or other treatments would clearly be warranted. The injured worker complains of chronic radicular low back pain. Physician report at the time of requested service under review shows that a Home exercise program has also been recommended. Documentation fails to show a significant loss of ability to function and there is no evidence to support that all

other treatment modalities have been recommended and deemed unsuccessful. The request Pain Management Referral is not medically necessary.

Psyche Bio Behavioral Pain Management: 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 Behavioral Interventions Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Psychological Treatment.

Decision rationale: Per guidelines, the identification and reinforcement of coping skills is often more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence. Initial trial of 3-4 psychotherapy visits over 2 weeks is recommended for patients who show no progress after 4 weeks of physical medicine alone. ODG recommends up to 13-20 visits over 7-20 weeks of individual sessions, if progress is being made as indicated by evidence of objective functional improvement. Per guidelines, the provider should evaluate symptom improvement during the process, so treatment failures can be identified early and alternative treatment strategies can be pursued if appropriate. Documentation shows that the injured worker has stress syndrome. There is lack of evidence that the Primary Care Physician has maximized therapeutic options to establish the medical necessity for Behavioral Pain Management Consult. The request for Psyche Bio Behavioral Pain Management is not medically necessary by lack of meeting MTUS or ODG per guidelines.

Flurbiprofen/Capsaicin/Camphor 10/0.025%, 2%, 1% 120gm: Upheld

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

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

Decision rationale: MTUS states that use of topical analgesics is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Flurbiprofen is not FDA approved for topical application. MTUS provides no evidence recommending the use of topical Camphor. Per guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request for: Flurbiprofen/Capsaicin/Camphor 10/0.025%, 2%, 1% 120gm is not medically necessary.

Ketoprofen/Cyclobenzaprine/Lidocaine 10%, 3%, 5% 120gm: 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.

Decision rationale: MTUS states that topical NSAIDs are not recommended for neuropathic pain, but may be useful for short-term treatment (4-12 weeks) of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). Topical NSAIDs have not been evaluated for treatment of the spine, hip or shoulder. There are no long-term studies of their effectiveness or safety. Per MTUS, Ketoprofen is not recommended and is not currently FDA approved for a topical application. Additionally, the use of muscle relaxants as a topical agent is not recommended. The request Ketoprofen/Cyclobenzaprine/Lidocaine 10%, 3%, 5% 120gm is not medically necessary, by MTUS.

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) Treatment in Workers Compensation; Medical Food.

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: 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%). Per ODG, medical foods are not recommended for treatment of chronic pain as they have not been shown to produce meaningful benefits or improvements in functional outcomes. Documentation fails to show objective evidence supporting the medical necessity for a medical food in the treatment of this injured worker. The request for Theramine #90 is not medically necessary.

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) Treatment in Workers Compensation; Medical Food.

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, Medications, Sentra PM.

Decision rationale: Sentra PM is a medical food for use in management of sleep disorders associated with depression. It is a proprietary blend of choline bitartrate, glutamate, and 5-hydroxytryptophan, hawthorn berry, cocoa, ginkgo biloba, and acetyl L-carnitine. Per ODG, medical foods are not recommended for treatment of chronic pain as they have not been shown to produce meaningful benefits or improvements in functional outcomes. Documentation shows

that the injured worker is diagnosed with Insomnia. There is no objective evidence provided to support the medical necessity for a medical food in the presence of established treatment guidelines utilizing prescription medications. The request for Sentra PM #60 is not medically necessary.

Flexeril/Cyclobenzaprine 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 41.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63.

Decision rationale: Cyclobenzaprine (Flexeril) is a skeletal muscle relaxant and a central nervous system depressant recommended as a treatment option to decrease muscle spasm in conditions such as low back pain. Per MTUS guidelines, muscle relaxants are recommended for use with caution as a second-line option for only short-term treatment of acute exacerbations in patients with chronic low back pain. The greatest effect appears to be in the first 4 days of treatment and appears to diminish over time. Prolonged use can lead to dependence. Documentation fails to indicate acute exacerbation or significant improvement in the injured worker's pain or functional status to justify continued use of cyclobenzaprine. The request for Flexeril/Cyclobenzaprine 7.5mg #60 is not medically necessary per MTUS guidelines.

Ultracet/Tramadol ER 150mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Tramadol Page(s): 77, 113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Opioids, specific drug list.

Decision rationale: MTUS recommends that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects must be documented with the use of Opioids. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Tramadol is a centrally acting analgesic reported to be effective in managing neuropathic pain. Per MTUS guidelines, there are no long-term studies to allow use of Tramadol for longer than three months. Ultracet is a combination of Acetaminophen and Tramadol. Documentation fails to demonstrate significant improvement in pain or level of function, to justify the ongoing use of Ultracet. With MTUS guidelines not being met, the request for Ultracet/Tramadol ER 150mg #60 is not medically necessary.

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 (ODG) Treatment in Workers Compensation; Medical Food.

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: Gabadone is a Medical food used to meet the nutritional requirements for sleep disorders and sleep disorders associated with insomnia. It contains combination of choline bitartrate, glutamic acid, 5-hydroxytryptophan, GABA, grape seed extract, griffonia extract, whey protein, valerian extract, ginkgo biloba and cocoa. ODG does not recommend the use of Gabadone. The injured worker is diagnosed with Insomnia. The use of Gabadone is however not recommended by guidelines. The request for Gabadone is not medically necessary by ODG.

Sudo Scan: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.ncbi.nlm.nih.gov/pmc/articles/PMC3817891.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Diabetes Chapter, SudoScan and Other Medical Treatment Guidelines <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3817891/>.

Decision rationale: Sudoscan is an autonomic nervous system function test, an alternative means of evaluating for sudomotor dysfunction, an early detectable abnormality in Diabetic small fiber neuropathy. The Sudoscan is a non-invasive method to measure sweat gland function. A low voltage potential of varying current is applied to electrodes on which the hands and feet are placed. Chloride from sweat glands is extracted producing a current (electrochemical skin conductance - ESC). ODG does not recommend Sudoscan, as there is a lack of evidence showing that this device improves patient management. Per guidelines, the request for Sudoscan is not medically necessary.

Autonomic Nervous Study: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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, Autonomic Nervous System Function Testing and Other Medical Treatment Guidelines [http://www.mayoclinic.org/diseases-conditions/autonomic- neuropathy/http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3278937/](http://www.mayoclinic.org/diseases-conditions/autonomic-neuropathy/http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3278937/).

Decision rationale: Autonomic neuropathy is a possible complication of some types of diseases such as Diabetes and Reflex Sympathetic Dystrophy. Various procedures are utilized as diagnostic tools to detect fiber neuropathy and autonomic dysfunction, most of which are for research purposes. Autonomic nervous system testing can be grouped into three categories, sudomotor, cardiovagal innervation, and vasomotor adrenergic innervation. ODG does not recommend Autonomic Nervous System Function Testing as a diagnostic test. Per guidelines, the request for Autonomic Nervous Study is not medically necessary per guidelines.