MAXIMUS Federal Services

Case Number:	CM14-0181767		
Date Assigned:	11/06/2014	Date of Injury:	08/29/2011
Decision Date:	12/15/2014	UR Denial Date:	10/14/2014
Priority:	Standard	Application Received:	11/03/2014

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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 57-year-old male with an 8/29/11 date of injury. At the time (9/12/14) of the request for authorization for Retrospective for date of service 9/12/14 Sentra AM #60; Retrospective for date of service 9/12/14 Sentra PM #60; Retrospective for date of service 9/12/14 Theramine #90; Retrospective for date of service 9/15/14 Hydrocodone/APAP 2.5/325mg #30, 30 day supply; Retrospective Lidocaine patch (unspecified); therapeutic exercises; and Spanish interpreter for all physician visits, there is documentation of subjective (complains of dysesthesia) and objective (none specified) findings, current diagnoses (lumbar disk disease), and treatment to date (medication including ongoing use of opioids). Regarding Retrospective for date of service 9/12/14 Sentra AM #60 and Retrospective for date of service 9/12/14 Sentra PM #60, there is no documentation that the product is a food for oral or tube feeding and labeled for dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements. Regarding Retrospective for date of service 9/15/14 Hydrocodone/APAP 2.5/325mg #30, 30 day supply, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications with Hydrocodone/APAP use to date. Regarding Retrospective Lidocaine patch (unspecified), there is no documentation that a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica) has failed. Regarding therapeutic exercises, it is not clear if this is a request for initial or additional (where physical therapy provided to date may have already exceeded guidelines regarding frequency) physical therapy. Regarding Spanish interpreter for all physician visits,

there is no documentation that the request represents medical treatment that should be reviewed for medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective (DOS 9/12/14) for Sentra AM #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation http://www.odg-twc.com/odgtwclist.htm

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 and http://www.ptlcentral.com/medical-foods-products.php.

Decision rationale: An online source identifies Sentra AM as a Medical Food, consisting of a proprietary formulation of amino acids and polyphenol ingredients in specific proportions, for the nutritional management of the altered metabolic processes of sleep disorders associated with depression. MTUS does not address the issue. ODG identifies that the product must be a food for oral or tube feeding; must be labeled for dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and must be used under medical supervision; as criteria to support the medical necessity of medial food. Within the medical information available for review, there is documentation of diagnoses of lumbar disk disease. In addition, there is documentation that it is used under medical supervision. However, there is no documentation that the product is a food for oral or tube feeding and labeled for dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements. Therefore, based on guidelines and a review of the evidence, the request for Retrospective for date of service 9/12/14 Sentra AM #60 is not medically necessary.

Retrospective (DOS 9/12/14) Sentra PM #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.odg-twc.com/odgtwclist.htm

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 and http://www.ptlcentral.com/medical-foods-products.php

Decision rationale: An online source identifies Sentra PM as a Medical Food, consisting of a proprietary formulation of amino acids and polyphenol ingredients in specific proportions, for the nutritional management of the altered metabolic processes of sleep disorders associated with depression. MTUS does not address the issue. ODG identifies that the product must be a food for oral or tube feeding; must be labeled for dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and must be used under medical supervision; as criteria to support the medical necessity of medial food. Within the

medical information available for review, there is documentation of diagnoses of lumbar disk disease. In addition, there is documentation that it is used under medical supervision. However, there is no documentation that the product is a food for oral or tube feeding and labeled for dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements. Therefore, based on guidelines and a review of the evidence, the request for Retrospective for date of service 9/12/14 Sentra PM #60 is not medically necessary.

Retrospective (DOS 9/12/14) Theramine #90: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation http://www.odg-twc.com/odgtwclist.htm

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

Decision rationale: MTUS does not address the issue. ODG identifies that Theramine is not recommended for the treatment of chronic pain. Therefore, based on guidelines and a review of the evidence, the request for Retrospective (DOS 9/12/14) Theramine #90 is not medically necessary.

Retrospective (DOS 9/15/14) Hydrocodone/APAP 2.5/325mg #30, 30 day supply: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80. Decision based on Non-MTUS Citation Title 8, California Code of Regulations

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbar disk disease. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, given documentation of ongoing treatment with opioids, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications with Hydrocodone/APAP use to date. Therefore, based on guidelines and a review of the evidence, the request for Retrospective (DOS 9/15/14) Hydrocodone/APAP is not medically necessary.

Retrospective Lidocaine patch (unspecified): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56-57. Decision based on Non-MTUS Citation Title 8, California Code of Regulations,

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain after there has been evidence that a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica) has failed, as criteria necessary to support the medical necessity of a lidocaine patch. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbar disk disease. In addition, there is documentation of neuropathic pain. However, there is no documentation that a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica) has failed. Therefore, based on guidelines and a review of the evidence, the request for Retrospective Lidocaine patch (unspecified) is not medically necessary.

Therapeutic Exercises: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.odg-twc.com/

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Physical Therapy, and Title 8, California Code of Regulations

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG recommends a limited course of physical therapy for patients with a diagnosis of radiculitis not to exceed 12 visits over 8 weeks. ODG also notes patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of lumbar disk disease. However, it is not clear if this is a request for initial or

additional (where physical therapy provided to date may have already exceeded guidelines regarding frequency) physical therapy. Therefore, based on guidelines and a review of the evidence, the request for therapeutic exercises is not medically necessary.

Spanish Interpreter for all Physician Visits: 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.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions

Decision rationale: MTUS and ODG do not address this issue. Medical Treatment Guideline identifies documentation that the request represents medical treatment in order to be reviewed for medical necessity, as criteria necessary to support the medical necessity of the requested Spanish interpreter for all physician visits. A search of online resources failed to provide any articles/studies addressing criteria for the medical necessity for the requested Spanish interpreter for all physician visits. Within the medical information available for review, there is documentation of diagnoses of lumbar disk disease. However, there is no documentation that the request represents medical treatment that should be reviewed for medical necessity. Therefore, based on guidelines and a review of the evidence, the request for Spanish interpreter for all physician visits is not medically necessary.