MAXIMUS Federal Services

Case Number:	CM14-0095700		
Date Assigned:	09/22/2014	Date of Injury:	05/18/2006
Decision Date:	10/21/2014	UR Denial Date:	05/20/2014
Priority:	Standard	Application Received:	06/19/2014

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 Occupational Medicine 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 70-year-old male with a 5/18/06 date of injury. At the time (5/29/14) of the Decision for Retrospective Terocin Patch #20 (DOS 2/28/14); Retrospective Menthoderm Gel #240 (DOS 2/28/14); Gaviscon ES 2 bottles 12 oz; Norco 10/325mg #135; Lidoderm Patch 5% #30; Temazepam 30mg #30; Retrospective Theramine #90 (DOS 2/28/14); Retrospective Trepadone #120 (DOS 2/28/14); Retrospective Sentra AM #60 (DOS 2/28/14); Retrospective Sentra PM #60 (DOS 2/28/14); Retrospective Gabadone #60 (DOS 2/28/14); Flurbi NAP cream LA 180gms (Flurbiprofen 20% Lidocaine 5% Amitriptyline 1%); Gabacyclotram 180gms (Gabapentin 10% Cyclobenzaprine 6% Tramadol 10%); Somnicin #30 (Melatonin 2mg, 5HTP 50mg, L tryptophan 100mg, Pyridoxine 10mg, Magnesium 50mg); Retrospective Urine Drug Screening (DOS 2/28/14); and Terocin 120 ml (Capsaicin 0.025% - Methyl Salicylate 25%-Menthol 10%), there is documentation of subjective (low back pain radiating to the lower extremities with numbness and tingling) and objective (decreased lumbar spine range of motion and antalgic gait) findings, current diagnoses (lumbar radiculitis, lumbar disc protrusion, bilateral knee internal derangement, and bilateral knee osteoarthritis), and treatment to date (medications (including ongoing treatment with Temazepam, Lidoderm patches, and Norco)). Medical report identifies that topical creams/patches decrease pain, increase sleep, and allow him to walk longer; a request for Omeprazole for gastrointestinal irritation; a request for Genicin for arthritis; and a request for Somnicin for treatment of insomnia, anxiety, and muscle relaxation. Regarding Menthoderm Gel, there is no documentation trial of antidepressants and anticonvulsants have failed. Regarding Gaviscon, there is no documentation of a condition/diagnosis (with supportive clinical findings) for which Gaviscon is indicated (heartburn, indigestion, and upset stomach). Regarding Norco, there is no 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; 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 as a result of Norco use to date. Regarding Lidoderm Patch, 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 Trepadone, Sentra, Gabadone, and Somnicin, there is no documentation identifying that the product is a food for oral or tube feeding; that is labeled for dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and that is used under medical supervision. Regarding urine drug screen, there is no documentation of abuse, addiction, or poor pain control.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Terocin Patch #20 (DOS 2/28/14): 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): 111-113.

Decision rationale: Terocin patch contains ingredients that include Lidocaine and Menthol. MTUS Chronic Pain Medical Treatment Guidelines identifies that many agents are compounded as monotherapy or in combination for pain control; that Ketoprofen, Lidocaine (in creams, lotion or gels), capsaicin in a 0.0375% formulation, baclofen and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications; and that any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Within the medical information available for review, there is documentation of diagnoses of lumbar radiculitis, lumbar disc protrusion, bilateral knee internal derangement, and bilateral knee osteoarthritis. However, Terocin contains at least one drug (Lidocaine) that is not recommended. Therefore, based on guidelines and a review of the evidence, the request for Retrospective Terocin Patch #20 (DOS 2/28/14) is not medically necessary.

Retrospective Menthoderm Gel #240 (DOS 2/28/14): 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): 111-112. Decision based on Non-MTUS Citation http://www.drugs.com/cdi/menthoderm-cream.html

Decision rationale: Medical Treatment Guideline identifies Menthoderm cream as a topical analgesic containing Methyl Salicylate and Menthol. MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain when trial of antidepressants and anticonvulsants have failed, as criteria necessary to support the medical necessity of topical analgesics. Within the medical information available for review, there is documentation of diagnoses of lumbar radiculitis, lumbar disc protrusion, bilateral knee internal derangement, and bilateral knee osteoarthritis. In addition, there is documentation of neuropathic pain. However, there is no documentation trial of antidepressants and anticonvulsants have failed. Therefore, based on guidelines and a review of the evidence, the request for retrospective Menthoderm Gel #240 (DOS 2/28/14) is not medically necessary.

Gaviscon ES 2 bottles 12 oz: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation WebMD.com

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (http://www.webmd.com/drugs/mono-2123 CALCIUM+CARBONATE+ANTACID+-+ORAL.aspx?drugid=18801&drugname=Gaviscon+oral)

Decision rationale: MTUS and ODG do not address this issue. Medical Treatment Guideline identifies that Gaviscon (aluminum/magnesium trisilicate) is an antacid that works by neutralizing acid in the stomach. In addition, Medical Treatment Guideline identifies documentation of a condition/diagnosis (with supportive clinical findings) for which Gaviscon is indicated (such as heartburn, indigestion, and upset stomach), as criteria necessary to support the medical necessity of Gaviscon. Within the medical information available for review, there is documentation of diagnoses of lumbar radiculitis, lumbar disc protrusion, bilateral knee internal derangement, and bilateral knee osteoarthritis. However, despite documentation of gastrointestinal irritation, there is no documentation of a condition/diagnosis (with supportive clinical findings) for which Gaviscon is indicated (heartburn, indigestion, and upset stomach). Therefore, based on guidelines and a review of the evidence, the request for Gaviscon ES 2 bottles 12oz is not medically necessary.

Norco 10/325mg #135: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Chapter Opioids

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, section 9792.20

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 radiculitis, lumbar disc protrusion, bilateral knee internal derangement, and bilateral knee osteoarthritis. In addition, there is documentation of ongoing treatment with Norco. 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; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, 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 as a result of Norco use to date. Therefore, based on guidelines and a review of the evidence, the request for Norco 10/325mg #135 is not medically necessary.

Lidoderm Patch 5% #30: 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, section 9792.20

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 radiculitis, lumbar disc protrusion, bilateral knee internal derangement, and bilateral knee osteoarthritis. In addition, there is documentation of ongoing treatment with Norco. 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; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, 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 as a result of Norco use to date. Therefore, based on guidelines and a review of the evidence, the request for Norco 10/325mg #135 is not medically necessary.

Temazepam 30mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Antidepressants. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that benzodiazepines are not recommended for long-term and that most guidelines limit use to 4 weeks. 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 radiculitis, lumbar disc protrusion, bilateral knee internal derangement, and bilateral knee osteoarthritis. In addition, there is documentation of ongoing treatment with Temazepam. However, there is no documentation of the intention to treat over a short course (up to 4 weeks). Therefore, based on guidelines and a review of the evidence, the request for Temazepam 30mg #30 is not medically necessary.

Retrospective Theramine #90 (DOS 2/28/14): Upheld

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

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 a medical food and is not recommended. Therefore, based on guidelines and a review of the evidence, the request for retrospective Theramine #90 (DOS 2/28/14) is not medically necessary.

Retrospective Trepadone #120 (DOS 2/28/14): Upheld

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

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, Trepadone; Medical Food and Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS does not address the issue. ODG identifies Trepadone as a medical food consisting of a proprietary blend of L-arginine, L-glutamine, Choline bitartrate, L-serine

and Gammaaminobutyric acid [GABA] used in the management of joint disorders associated with pain and inflammation. 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 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 medical food. Within the medical information available for review, there is documentation of diagnoses of lumbar radiculitis, lumbar disc protrusion, bilateral knee internal derangement, and bilateral knee osteoarthritis. In addition, there is documentation of a recommendation for Trepadone, a medical food. However, there is no documentation identifying that the product is a food for oral or tube feeding; that is labeled for dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and that is used under medical supervision. Therefore, based on guidelines and a review of the evidence, the request for retrospective Trepadone #120 (DOS 2/28/14) is not medically necessary.

Retrospective Sentra AM #60 (DOS 2/28/14): 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 Official Disability Guidelines (ODG) Pain Chapter, Medical Foods and Title 8, California Code of Regulations, section 9792.20; 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 associated with fatigue and cognitive disorders. MTUS does not address the issue. 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 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 radiculitis, lumbar disc protrusion, bilateral knee internal derangement, and bilateral knee osteoarthritis. In addition, there is documentation of a recommendation for Sentra, a medical food. However, there is no documentation identifying that the product is a food for oral or tube feeding; that is labeled for dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and that is used under medical supervision. Therefore, based on guidelines and a review of the evidence, the request for retrospective Sentra AM #60 (DOS 2/28/14) is not medically necessary.

Retrospective Sentra PM #60 (DOS 2/28/14): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Mental and Stress Chapter, Pain Chapter

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 Title 8, California Code of Regulations, section 9792.20; 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. 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 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 radiculitis, lumbar disc protrusion, bilateral knee internal derangement, and bilateral knee osteoarthritis. In addition, there is documentation of a recommendation for Sentra, a medical food. However, there is no documentation identifying that the product is a food for oral or tube feeding; that is labeled for dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and that is used under medical supervision. Therefore, based on guidelines and a review of the evidence, the request for retrospective Sentra PM #60 (DOS 2/28/14) is not medically necessary.

Retrospective Gabadone #60 (DOS 2/28/14): Upheld

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

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 and Title 8, California Code of Regulations, section 9792.20; and http://www.ptlcentral.com/medical-foods-products.php

Decision rationale: An online source identifies Gabadone 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 anxiety. MTUS does not address the issue. 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 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 radiculitis, lumbar disc protrusion, bilateral knee internal derangement, and bilateral knee osteoarthritis. In addition, there is documentation of a recommendation for Sentra, a medical food. However, there is no documentation identifying that the product is a food for oral or tube feeding; that is labeled for dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and that is used under medical supervision. Therefore, based on guidelines and a review of the evidence, the request for retrospective Gabadone #60 (DOS 2/28/14) is not medically necessary.

Flurbi NAP cream LA 180gms (Flurbiprofen 20% Lidocaine 5% Amitriptyline 1%): 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): 111-113.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that many agents are compounded as monotherapy or in combination for pain control; that Ketoprofen, Lidocaine (in creams, lotion or gels), capsaicin in a 0.0375% formulation, baclofen and other muscle relaxants, and Gabapentin and other antiepilepsy drugs are not recommended for topical applications; and that any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Therefore, based on guidelines and a review of the evidence, the request for Flurbi NAP cream LA 180gms (Flurbiprofen 20% Lidocaine 5% Amitriptyline 1%) is not medically necessary.

Gabacyclotram 180gms (Gabapentin 10% Cyclobenzaprine 6% Tramadol 10%): 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): 111-113.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that many agents are compounded as monotherapy or in combination for pain control; that Ketoprofen, Lidocaine (in creams, lotion or gels), capsaicin in a 0.0375% formulation, baclofen and other muscle relaxants, and Gabapentin and other antiepilepsy drugs are not recommended for topical applications; and that any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Therefore, based on guidelines and a review of the

evidence, the request for Gabacyclotram 180gms (Gabapentin 10% Cyclobenzaprine 6% Tramadol 10%) is not medically necessary.

Somnicin #30 (Melatonin 2mg, 5HTP 50mg, Ltryptophan 100mg, Pyridoxine 10mg Magnesium 50mg): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Chapter, Medical Foods

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

Decision rationale: Somnicin is a combination of ingredients that are all naturally-occurring within the body: Melatonin, 5-hydroxytryptophan, L-tryptophan, Vitamin B6, and Magnesium. MTUS does not address the issue. ODG identifies 5-hydroxytryptophan as a medical food product, defined as a food which is formulated to be consumed or administered entirely under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation. In addition, 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 radiculitis, lumbar disc protrusion, bilateral knee internal derangement, and bilateral knee osteoarthritis. In addition, there is documentation of a recommendation for Sentra, a medical food. However, there is no documentation identifying that the product is a food for oral or tube feeding; that is labeled for dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and that is used under medical supervision. Therefore, based on guidelines and a review of the evidence, the request for Somnicin #30 (Melatonin 2mg, 5HTP 50mg, L tryptophan 100mg, Pyridoxine 10mg, and Magnesium 50mg) is not medically necessary.

Retrospective Urine Drug Screening (DOS 2/28/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids and Criteria for Management.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 78.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of abuse, addiction, or poor pain control in patient under on-going opioid treatment, as criteria necessary to support the medical necessity of Urine Drug Screen. Within the medical information available for review, there is documentation of diagnoses of lumbar

radiculitis, lumbar disc protrusion, bilateral knee internal derangement, and bilateral knee osteoarthritis. In addition, there is documentation of ongoing treatment with opioids. However, there is no documentation of abuse, addiction, or poor pain control. Therefore, based on guidelines and a review of the evidence, the request for retrospective Urine Drug Screening (DOS 2/28/14) is not medically necessary.