

Case Number:	CM15-0177775		
Date Assigned:	09/28/2015	Date of Injury:	07/07/2014
Decision Date:	12/01/2015	UR Denial Date:	08/26/2015
Priority:	Standard	Application Received:	09/09/2015

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: Texas, Florida
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 45 year old male who sustained an industrial injury on 7-7-2014. A review of medical records indicated the injured worker is being treated for lumbar disc protrusion and lumbar radiculopathy. The 2/27/2015 MRI of the lumbar spine showed L4-L5, L5-S1 disc bulges without significant neural foramina stenosis. The X-ray of the lumbar spine was noted to be normal. The 3/24/2015 EMG/NCV studies of the lumbar spine showed left L5 radiculopathy. The 6/12/2015 lumbar epidural steroid injection was noted to result in 50% pain relief for 3 days. Medical records dated 6-23-2015 noted lower back pain and leg pain rated a 7 out of 10. Pain was unchanged from the prior visit. Physical examination noted decreased lumbar range of motion. There was tenderness and palpable spasms along the paravertebral muscles of the lumbar spine bilaterally. Straight leg raise was positive on the right. Treatment has included LESI injections with 50% improvement, physical therapy, Naproxen since at least 2-12-2015, Theramine since 4-28-2015 and Norco. Per the injured worker, medications do not provide functional improvement. He has also been treated with topical medications since at least 2-12-2015. Utilization review form dated 8-26-2015 non-certified terocin patches, Ketoprofen10%- Gabapentin6%-Bupivacaine5%-Flutic1%- Baclofen2%-Cyclobenz2%-Clonidine2%- HyalAcid2%, Pentoxifyline5%-Aminophylline3%- Lidocaine25%-Hyaluronic Acid 1%, Theramine, Sentra AM, Sentra PM, Gabadone, Right L4-5 ESI, and 120ml ALA125mg) .5mg HyalAcid (B12) 0.5-Pyridox-5-Phos35mg-reveratrol 25mg-CoQ10 50 mg-VD3 500IU.

IMR ISSUES, DECISIONS AND RATIONALES

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

Terocin patches qty: 30.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Capsaicin, topical, Lidoderm (lidocaine patch), Medications for chronic pain, Salicylate topicals, Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Topical Analgesics.

Decision rationale: The CA MTUS and the ODG guidelines recommend that topical analgesics can be utilized for the treatment of localized neuropathic pain when first line orally administered anticonvulsant and antidepressant medications cannot be tolerated or are ineffective. The guidelines recommend that topical medications be tried and evaluated individually for efficacy. The records did not show subjective or objective findings of localized neuropathic pain such as CRPS. There is no documentation of failure of treatment with first line medications. The Terocin patches contain menthol 10% / lidocaine 2.5% / capsaicin 0.025% / methyl salicylate 25%. There is lack of guidelines support for the utilization of topical formulation of menthol and methyl salicylate for the treatment of chronic musculoskeletal pain. The criteria for the use of Terocin patches #30 was not met. The request is not medically necessary.

Ketoprofen 10%, Gabapentin 6%, Bupivacaine 5%, Flutic 1%, Baclofen 2%, Cyclobenz 2%, Clonidine .2%, HyalAcid .2% qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain, Anti-epilepsy drugs (AEDs), Capsaicin, topical, Lidoderm (lidocaine patch), Medications for chronic pain, NSAIDs (non-steroidal anti-inflammatory drugs), Salicylate topicals, Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Topical Analgesics.

Decision rationale: The CA MTUS and the ODG guidelines recommend that topical analgesics can be utilized for the treatment of localized neuropathic pain when first line orally administered anticonvulsant and antidepressant medications cannot be tolerated or are ineffective. The guidelines recommend that topical medications be tried and evaluated individually for efficacy. The records did not show subjective or objective findings of localized neuropathic pain such as CRPS. There is no documentation of failure of treatment with first line medications. There is lack of guidelines support for the utilization of topical formulation of ketoprofen, gabapentin, baclofen, cyclobenzaprine, clonidine, flutic, hyaluronic acid for the treatment of chronic musculoskeletal pain. The criteria for the use of ketoprofen 10% / gabapentin 6% / bupivacaine 5% / flutic 1% / baclofen 2% / cyclobenzaprine 2% / clonidine .2% / hyaluronic acid 0.2% qty 1 was not met. The request is not medically necessary.

Pentoxifyline 5%-Aminophyline 3%-Lidocaine 25%-Hyaluronic Acid 1% 240gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Medications for chronic pain, Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Topical Analgesic.

Decision rationale: The CA MTUS and the ODG guidelines recommend that topical analgesics can be utilized for the treatment of localized neuropathic pain when first line orally administered anticonvulsant and antidepressant medications cannot be tolerated or are ineffective. The guidelines recommend that topical medications be tried and evaluated individually for efficacy. The records did not show subjective or objective findings of localized neuropathic pain such as CRPS. There is no documentation of failure of treatment with first line medications. There is lack of guidelines support for the utilization of topical formulation of pentoxifyline, aminophyline or hyaluronic acid for the treatment of chronic musculoskeletal pain. The criteria for the use of pentoxifyline 5% / aminophyline 3% / lidocaine 25% /hyaluronic acid 1% 240gm was not met. The request is not medically necessary.

Theramine qty: 180.00: 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), Medical food.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Medications for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Medical Food.

Decision rationale: The CA MTUS and the ODG guidelines did not recommend that use of medical food and nutritional supplements because of lack of standardized clinical reports supporting the utilization of these products. The guidelines noted the absence of FDA support of the beneficial effect in the absence of established deficiency states. The guidelines noted the availability of FDA approved medications for the treatment of the listed conditions. The records indicated that Theramine was being utilized for the treatment of painful joints inflammation. There is no documentation of nutritional deficiencies associated with the use of Theramine. The criteria for the use of Theramine #180 was not met. The request is not medically necessary.

Sentra AM qty: 60.00: 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), Medical food.

MAXIMUS guideline: Decision based on MTUS Stress-Related Conditions 2004, Section(s): Treatment, and Chronic Pain Medical Treatment 2009, Section(s): Medications for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Mental Illness and Stress.

Decision rationale: The CA MTUS and the ODG guidelines did not recommend that use of medical food and nutritional supplements because of lack of standardized clinical reports supporting the utilization of these products. The guidelines noted the absence of FDA support of the beneficial effect in the absence of established deficiency states. The guidelines noted the availability of FDA approved medications for the treatment of the listed conditions. The records indicated that Sentra was being utilized for the treatment of psychosomatic conditions. There is no documentation of nutritional deficiencies or failure of treatment with FDA approved psychiatric medications. The criteria for the use of Sentra AM #60 was not met. The request is not medically necessary.

Sentra PM qty: 60.00: 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), Medical food.

MAXIMUS guideline: Decision based on MTUS Stress-Related Conditions 2004, Section(s): Treatment, and Chronic Pain Medical Treatment 2009, Section(s): Medications for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Mental Illness and Stress.

Decision rationale: The CA MTUS and the ODG guidelines did not recommend that use of medical food and nutritional supplements because of lack of standardized clinical reports supporting the utilization of these products. The guidelines noted the absence of FDA support of the beneficial effect in the absence of established deficiency states. The guidelines noted the availability of FDA approved medications for the treatment of the listed conditions. The records indicated that Sentra PM was being utilized for the treatment of insomnia and anxiety. There is no documentation of nutritional deficiencies or failure of treatment with FDA approved psychiatric medications. The criteria for the use of Sentra PM #60 was not met. The request is not medically necessary.

GABAdone qty: 60.00: 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), Medical food.

MAXIMUS guideline: Decision based on MTUS Stress-Related Conditions 2004, Section(s): Treatment, and Chronic Pain Medical Treatment 2009, Section(s): Anti-inflammatory medications, Medications for chronic pain, Nonprescription medications. Decision based on

Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Medical Food Mental Illness and Stress.

Decision rationale: The CA MTUS and the ODG guidelines did not recommend that use of medical food and nutritional supplements because of lack of standardized clinical reports supporting the utilization of these products. The guidelines noted the absence of FDA support of the beneficial effect in the absence of established deficiency states. The guidelines noted the availability of FDA approved medications for the treatment of the listed conditions. The records indicated that Gabadone was being utilized for the treatment of insomnia and anxiety. There is no documentation of nutritional deficiencies or failure of treatment with standard FDA approved medications. The criteria for the use of Gabadone # 60 was not met. The request is not medically necessary.

Right L4-5 epidural steroid injection qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations, and Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs), Medications for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Low Back Epidural Injections.

Decision rationale: The CA MTUS and the ODG guidelines recommend that epidural steroid injections can be utilized for the treatment of lumbar radiculopathy when conservative treatment with medications, exercise and PT have failed. The guidelines recommend that epidural steroid injection can be repeated when there is documentation of significant pain relief and functional restoration for more than 3-6 months. The records indicate that the patient had subjective, objective and radiological findings consistent with the diagnosis of lumbar radiculopathy. The documents show that the last lumbar epidural steroid injection resulted in 50% pain relief for only 3 days. The criteria for the Right L4-L5 lumbar epidural steroid injection QTY1 was not met. The request is not medically necessary.

ALA125mg-B9 0.5mg-HyalAcid-(B12) 0.5mg-Pyridox-5-Phos35mg-Resveratrol25mg-CoQ10 50mg-VD3 500IU qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Medications for chronic pain, Nonprescription medications. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

Decision rationale: The CA MTUS and the ODG guidelines did not recommend that use of medical food and nutritional supplements because of lack of standardized clinical reports supporting the utilization of these products. The guidelines noted the absence of FDA support of

the beneficial effect in the absence of established deficiency states. The guidelines noted the availability of FDA approved medications for the treatment of the listed conditions. The records did not indicate the specific indication for the utilization for this combination of nutritional supplements. There is no documentation of nutritional deficiencies associated with the use utilization of this compound product. The criteria for the use of ALA125mg-B9 0.5mg-HyalAcid -(B12) 0.5mg-Pyridox-5-Phos35mg-Resveratrol 25mg-CoQ10 50mg-VD3 500IU qty: 1 was not met. The request is not medically necessary.