

Case Number:	CM14-0122317		
Date Assigned:	08/06/2014	Date of Injury:	11/27/2002
Decision Date:	09/11/2014	UR Denial Date:	07/23/2014
Priority:	Standard	Application Received:	08/01/2014

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 Emergency 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:

Patient with reported date of injury on 11/27/2002. No mechanism of injury was provided for review. Patient has a diagnosis of chronic low back pain, Chronic pain syndrome, lumbosacral radiculopathy, alcohol dependence, opiate dependence and methamphetamine dependence. Reported lumbar surgery from L4-S1 on 8/2010 and L hip fracture post surgical repair on 6/2012. Medical records reviewed. Last report available until 6/23/14. Many of the reports relate to chronic substance abuse issues and tend to be very brief when it comes to pain history and physical. Pt complains of low back pain and L leg numbness and weakness. No pain scale provided. Objective exam reveals tightness and tenderness to bilateral lumbosacral paraspinal muscles. No other exam provided. Patient has reported history of chronic drug abuse with use of methamphetamines. Patient has repeatedly failed attempts at drug rehabilitation. Last attempt failed due to "conflict with staff member". Patient reportedly has daily methamphetamine use and has been off from methamphetamine for only 2 days over the last 10 years. Discogram (3/2010) reported shows L3-4 and L4-5 tears. (original report not provided). No other advance imaging or electrodiagnostic reports provided for review. Multiple oral drug screens were positive for methamphetamines. Current medications include neurontin, prilosec, ambien, Lidoderm, Senokot, MSIR, Limbrel, Theramine and Ketoprofen ointment. Independent Medical Review is for Norco 10/325mg #120, Methadone 10mg #120, Voltaren gel #unknown, Prilosec 20mg #60, Lidoderm #unknown, Neurontin (unknown) mg #unknown, Ambien #unknown, Senokot #unknown, MS IR 15mg #unknown, Limbrel (unknown)mg #unknown, Theramine (unknown) mg #unknown and Ketoprofen ointment #unknown. Prior UR recommended non- certification.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg, Qty: 120: 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): 76-78.

Decision rationale: Norco is acetaminophen and hydrocodone, an opioid. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. Documentation does not meet the appropriate documentation or analgesia criteria. Patient has a known history of amphetamine and substance abuse leading to high risk of Norco abuse. There is no noted assessment for this abuse on record. Norco is not medically necessary.

Methadone 10mg, Qty:120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines METHADONE Page(s): 61-62.

Decision rationale: Methadone is a long acting opioid. As per MTUS guidelines, methadone is a second line treatment for pain. There are significant risks in methadone treatment that must be weighed against benefit. Patient has a history of amphetamine dependency/abuse and has a history of opiate dependency and is undergoing drug detox program with persistent failures. As part of a detox program, methadone is an appropriate secondary treatment for pain and weaning off opioid dependency in this patient due to risk of abuse of other opioids. However, this patient is already inappropriately on multiple opioids and has been on these opioids chronically with no noted plan for weaning off multiple opioids. This is not an appropriate use of methadone. As per MTUS guidelines, methadone treatment requires close monitoring due to risk of abuse and risk of adverse events. Several of the medications currently being taken by the pt has this risk. The number of tablets requested are excessive and do not meet the close monitoring requirement as required by the MTUS guidelines. The prescription of methadone is not medically appropriate or medically necessary.

Voltaren Gel (unspecified quantity): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines – TWC.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-112.

Decision rationale: Voltaren gel is a topical non-steroidal anti-inflammatory drug (NSAID). As per MTUS Chronic Pain guidelines, topical NSAIDs are inconsistent in pain control. It appears to be effective short term but little data shows its effectiveness long term. There is little evidence to support its use for spine and shoulder related pain. MTUS Guidelines also recommended short term use only(4-12 weeks). Pt appears to be using the gel in an area that is not supported by MTUS Guidelines and for at least 3-4 months. The continued use of Voltaren gel does not meet MTUS Chronic Pain guidelines and therefore is not medically necessary.

Prilosec 20mg, Qty: 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 - TWC

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS AND CARDIOVASCULAR RISK Page(s): 68-69.

Decision rationale: Prilosec is a proton-pump inhibitor (PPI) used for dyspepsia from NSAID use or gastritis/peptic ulcer disease. As per MTUS guidelines, PPIs may be used in patients with high risk for gastric bleeds or problems or signs of dyspepsia. Patient has "stomach upset" from medications and prilosec is reportedly "helping". However, MTUS Guidelines recommendations related to dyspepsia from NSAID use. Patient is not noted to be on any oral NSAIDs. It is not known if this "stomach upset" is related to nausea/constipation or a multitude of stomach complaints related to high dose opioids that patient is on or related to dyspepsia. Prilosec is not medically necessary.

Lidoderm patches (unspecified quantity): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines LIDODERM (LIDOCAINE PATCH) Page(s): 56-57.

Decision rationale: As per MTUS chronic pain guidelines, lidoderm is only approved for peripheral neuropathic pain, specifically post-herpetic neuralgia. there is poor evidence to support its use in other neuropathic pain conditions such as such as back pain. The lack of proper physical exam report also does not support its use. The request is also incomplete with no total number of tablets found in prescription or notes provided. Lidoderm patches are not medically necessary.

Neurontin (unspecified quantity): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIPILEPSY DRUGS (AEDS) Page(s): 18-19.

Decision rationale: Gabapentin (Neurontin) is an anti-epileptic drug with efficacy in neuropathic pain. Pt has no documentation of any neuropathic pain. Pt has also been on this medication for several years with no documentation improvement in pain. Pt does not meet any indication for use of Neurontin and it is therefore not medically necessary.

Ambien (unspecified quantity): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN (CHRONIC), INSOMNIA TREATMENT

Decision rationale: There is no specific sections in the MTUS chronic pain or ACOEM guidelines that relate to this topic. Ambien is a benzodiazepine agonist approved for insomnia. As per ODG guidelines, it recommends treatment of underlying cause of sleep disturbance and recommend short course of treatment. Patient has been on Ambien chronically at least 6 months. There is no documentation of other conservative attempts at treatment of sleep disturbance or sleep studies. The request is also incomplete with no total number of tablets found in prescription or notes provided. The chronic use of Ambien is not medically appropriate and is not medically necessary.

Senokot (unspecified quantity): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 77.

Decision rationale: Senokot is a medication used for constipation. As per MTUS Chronic pain guidelines, patient's on chronic opioid use should be placed on constipation prophylaxis. While the use of senokot is appropriate, the request is incomplete with no total number of tablets found in prescription or notes provided. An incomplete prescription cannot be approved. Senokot with an unknown number of tablets is not medically necessary.

MSIR 15mg: 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): 76-79.

Decision rationale: MSIR is Intermediate Release Morphine. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. Documentation does not meet the appropriate documentation or analgesia criteria. Patient has a known history of amphetamine and substance abuse leading to high risk of MSIR abuse. There is no noted assessment for this abuse on record. The prescription is also incomplete with no total number of tablets requested. Due to incomplete prescription and not meeting criteria, MSIR is not medically necessary.

Limbrel (unspecified quantity): Upheld

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

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: Limbrel is a brand name product, being sold by [REDACTED], containing multiple non-prescription generic substances including flavocoxid (a trademark non-prescription compound containing various flavinoids) and citrated zinc bisglycinate claimed by its manufacturer to aid in various "inflammatory conditions". There is only marketing information available online. It is marketed as a medical food/non-medicinal supplement. Similar to many of these "medical food" products, it makes multiple vague claims so as not to require FDA trials. There are no supporting good quality studies on the efficacy of this product. There is no corresponding sections in ACOEM or MTUS concerning these substances. The ODG indicates medical food is defined as "a food which is formulated to be consumed or internally 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." Documentation states that patient has chronic pain due to actual injuries. Patient has no documented nutritional deficiency causing pain. This patient has actual medical problems causing pain therefore a "medical food" is not indicated since there is no nutritional deficiency or documented nutritional special requirements. Limbrel is an unevicenced non-medicinal substance with unknown efficacy or safety profile and is not medically necessary.

Theramine (unspecified quantity): Upheld

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

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 brand name product, being sold by [REDACTED], containing multiple non-prescription generic substances including "amino acids and polyphenol ingredients" claimed by its manufacturer to aid in various "inflammatory conditions" and pains. There is only marketing information available online. It is marketed as a medical food/non-medicinal supplement. Similar to many of these "medical food" products, it makes multiple vague claims so as not to require FDA trials. There are no supporting good quality studies on the efficacy of this product. There is no corresponding sections in ACOEM or MTUS concerning these substances. The ODG indicates medical food is defined as "a food which is formulated to be consumed or internally 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." Documentation states that patient has chronic pain due to actual injuries. Patient has no documented nutritional deficiency causing pain. This patient has actual medical problems causing pain therefore a "medical food" is not indicated since there is no nutritional deficiency or documented nutritional special requirements. Theramine is an unevidenced non-medicinal substance with unknown efficacy or safety profile and is not medically necessary.

Ketoprofen ointment (unspecified quantity): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

Decision rationale: Ketoprofen is a Non-steroidal anti-inflammatory drug (NSAID). It is not FDA approved for use as a topical compound. As per MTUS chronic pain guidelines, topical NSAIDs have inconsistent results but is better than placebo for pain during initial 2weeks of pain with diminishing results over time. It is currently only recommended for short term use and for osteoarthritis of joints that are amenable for topical treatment(such as elbow or knees). There is no evidence to support its use for spine, hip or shoulder pains. In conclusion, NSAID topical are not recommended for long term use and there is no evidence to support its use for back related pain. A non-FDA approved use of Ketoprofen is not recommended and is not medically necessary.