

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM14-0149323 |                              |            |
| <b>Date Assigned:</b> | 09/18/2014   | <b>Date of Injury:</b>       | 11/18/2003 |
| <b>Decision Date:</b> | 10/20/2014   | <b>UR Denial Date:</b>       | 08/18/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/15/2014 |

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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:

The patient is a 60 year old male with an injury date of 11/18/03. Per the 07/11/14 progress report by [REDACTED], the patient presents with pain in the left side of the body rated 7/10 with medications and 9/10 without. Reports do not note if the patient is working. No physical examination notes were provided. The patient's diagnoses include: 1. Crush injury left foot; 2. Chronic pain syndrome; 3. Left foot reflex sympathetic dystrophy (aka Complex Regional Pain Syndrome); 4. Chronic pain related insomnia; 5. Neuropathic pain; 6. Chronic pain related depression; 7. Prescription narcotic dependence. Continuing medications are listed as, Benadryl, Norco, Gabadone, Percura, Fosamax, Remeron, Clonidine, and Fluriflex plus start Trepadone. It is noted in reports that the patient's psychiatrist reduced the dosage of Ambien. The utilization review being challenged is dated 08/18/14. Reports were provided from 01/13/14 to 03/04/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**BENADRYL 25MG 1-2 TABLETS DAILY QTY 60 FOR 2 MONTHS:** Overturned

**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) Insomnia Section

**Decision rationale:** The patient presents with pain in the left side of the body rated 7-9/10. The treating physician requests for: Benadryl (an anti-histamine) 25 mg 1-2 tablets daily Qty 60 for 2 months. Reports indicate it was continuing medication on 02/13/14 and the treating physician notes it helps the patient with sleep. MTUS is silent on Benadryl/antihistamines. ODG states the following, under the Insomnia treatment section, "Sedating antihistamines (primarily over-the-counter medications): Sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine [Benadryl, OTC in U.S.], promethazine [Phenergan, prescription in U.S., OTC in other countries]). Tolerance seems to develop within a few days." In this case, ODG suggests this medication to aid in sleep, and the treating physician states it is effective. Recommendation is that the request is medically necessary.

**NORCO 10/325MG 1 Q 4 HOURS QTY 180 FOR 2 MONTHS:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 78, 88, 89.

**Decision rationale:** The patient presents with pain in the left side of the body rated 7-9/10. The treating physician requests for: Norco (an opioid) 10/325 mg 1 Q 4 hours Qty 180 for 2 months. Reports provided show this as a continuing medication since at least 11/11/13. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief." The treating physician does assess pain with numerical scales noting the patient's pain as 7/10 with medications and 10/10 without from 02/13/14 to 06/08/14. On 07/11/14 it is noted the patient does well and is maintaining with current medications. This was in the context of all medications. Urine toxicology reports are referenced and/or provided for 06/18/14 which states "positive" (medication present) for Nicotine, Morphine, Hydrocodone, and hydromophone and on 01/13/14 states "positive" (medication present) for Hydrocodone. There is not full discussion of opiate management issues regarding side effects and behavior. There is, however, a diagnosis of prescription narcotic dependence. On 01/13/14 the treating physician notes, "The patient has difficulty with self-care. He needs help drying off and dressing following a shower. He is unable to shop, cook or clean for himself." It is further noted that the patient is primarily homebound, needs a wheelchair to leave home and is unable to drive. There is no discussion of a change with and without medications, and this is the only report addressing ADL's. Discussion and documentation has been sufficiently provided per MTUS guidelines above. Recommendation is that the request is medically necessary.

**GABADONE 2 TABLETS Q HS QTY 60 FOR 2 MONTHS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines 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 (Chronic) Section

**Decision rationale:** The patient presents with pain in the left side of the body rated 7-9/10. The treating physician requests for: Gabadone 2 tablets QHS Qty 60 for 2 months. Reports show the patient started this medication 03/25/14. ODG guidelines, Pain (Chronic) section state that GABAdone, " Not recommended. GABAdone is a medical food from Physician Therapeutics, Los Angeles, CA, that is a proprietary blend of Choline Bitartrate, Glutamic Acid, 5-Hydroxytryptophan, and GABA. It is intended to meet the nutritional requirements for inducing sleep, promoting restorative sleep and reducing snoring in patients who are experiencing anxiety related to sleep disorders." Therefore, recommendation is the request is not medically necessary.

**PERCURA 2 TABLETS PO TWICE DAILY QTY 120 FOR 2 MONTHS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - 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 (Chronic) Section

**Decision rationale:** The patient presents with pain in the left side of the body rated 7-9/10. The treating physician requests for: Percura 2 tablets po twice daily Qty 120 for 2 months. Reports provided show this as a continuing medication on 03/25/14. MTUS is silent on Percura. ODG Guidelines Pain (Chronic) section state the following about Percura, "Not recommended. Percura is a medical food from Physician Therapeutics, that is a proprietary blend of gamma-aminobutyric acid, choline bitartrate, L-arginine, L-serine, and other ingredients. It is intended for dietary management of metabolic processes associated with pain, inflammation and loss of sensation due to peripheral neuropathy." Recommendation is that the request is not medically necessary.

**TREPIDONE 2 TABLETS PO TWICE DAILY QTY 120 FOR 2 MONTHS:** Upheld

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

**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) Section

**Decision rationale:** The patient presents with pain in the left side of the body rated 7-9/10. The treating physician requests for: Trepadone 2 tablets po twice daily Qty 120 for 2 months. Reports show the patient started this medication 07/11/14. MTUS is silent on Trepadone. ODG Pain (Chronic) section guidelines state the following regarding Trepadone, "Not recommended for the treatment of chronic pain. Trepadone is a medical food from Targeted Medical Pharma Inc., Los Angeles, CA, that is a proprietary blend of L-arginine, L-glutamine, choline bitartrate, L-serine and gammaaminobutyric acid [GABA]. It is intended for use in the management of joint disorders associated with pain and inflammation." Recommendation is that the request is not medically necessary.

**FLURIFLEX 240GM TID FOR 2 MONTHS:** 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 TOPICAL ANALGESICS Page(s): 111.

**Decision rationale:** The patient presents with pain in the left side of the body rated 7-9/10. The treating physician requests for: Fluriflex 240 gm tid for 2 months. Fluriflex is a cyclobenzaprine cream. The MTUS has the following regarding topical creams (page 111, chronic pain section): "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case cyclobenzaprine is not supported for topical formulation. Recommendation is that the request is not medically necessary.