

Case Number:	CM13-0030781		
Date Assigned:	03/28/2014	Date of Injury:	04/05/2013
Decision Date:	05/23/2014	UR Denial Date:	09/05/2013
Priority:	Standard	Application Received:	10/01/2013

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:

The patient is a 36-year-old female with date of injury 04/05/2013. The patient is currently being treated by an orthopedist, who has requested gabapentin suspension, a hot cold therapy unit, and a TENS unit for purchase. At the time of the utilization review denial, 07/30/2013, the patient had the following subjective complaints: Burning/radicular low back pain, 7/10, constant, moderate to severe; burning bilateral knee pain, 7/10, constant, moderate to severe; and difficulty sleeping. The patient states that the medications offer her temporary relief of pain and improve her ability to have restful sleep. She denies any problems with medications. The pain is also alleviated by activity restrictions. Objective findings at the time of the examination were, in regard to the lumbar spine, ambulates without any assistive devices, pain with heel walking; able to squat to 50%; tender L5-S1 with decreased range of motion, positive straight leg raising, positive Kemp's sign. In regard to her knees 1+ effusion, crepitation with range of motion; tender patellofemoral joint. No ligament instability, decreased range of motion. The sensory exam states only decreased sensation with no dermatomal distribution. Decreased motor strength in the bilateral lower extremities without any grading. Medications: 1. Dicopanол 5mg, SIG: 1 at bedtime 2. Deprizine 5m, SIG: 1 once daily 3. Fanatrex 125mg, SIG: 1 t.i.d. 4. Synapryn 10mg, SIG: 1 three times a day 5. Tabredol 1mg, SIG: 1 tablet 2-3 times daily

IMR ISSUES, DECISIONS AND RATIONALES

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

FANATREX (GABAPENTIN) 25MG/ML 420ML: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 110.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 19.

Decision rationale: Fanatrex is a compounded oral suspension of gabapentin. Gabapentin is an anti-epilepsy drug which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The medical record does offer evidence of radiculopathy neuropathic pain and gabapentin, but there is no documentation why this patient must use a compounded oral suspension as opposed to taking tablets. Fanatrex (Gabapentin) 25MG/ML 420ML is not medically necessary

HOT/COLD THERAPY UNIT: E0217: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 300.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK - LUMBAR & THORACIC (ACUTE & CHRONIC), COLD PACKS.

Decision rationale: Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. The ODG cites no evidence that rotating heat and cold to the lumbar is effective in treating chronic lumbar pain. A Hot/Cold therapy machine is not medically necessary.

TENS UNIT - RENTAL/PURCHASE WITH SUPPLIES: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TRANSCUTANEOUS ELECTROTHERAPY Page(s): 114-117.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

Decision rationale: Not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option. The patient has not undergone a one month trial with a rental unit. The request is for both rental and purchase of the

unit, and stated as such, cannot be authorized. Tens Unit - Rental/Purchase with Supplies is not medically necessary.