

Case Number:	CM13-0035732		
Date Assigned:	12/13/2013	Date of Injury:	03/31/2006
Decision Date:	02/11/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	10/17/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation 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 physician 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.

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 45-year-old female who reported an injury on 03/31/2006. The patient is diagnosed as status post lumbar spine laminectomy with residual pain, anxiety disorder, and mood disorder. The patient was seen by [REDACTED] on 10/08/2013. Physical examination revealed well-healed incision in the midline lumbar spine, tenderness to palpation, diminished range of motion, positive tripod and flip test bilaterally, diminished sensation over the L4, L5, and S1 dermatomes, decreased motor strength in bilateral lower extremities, and 2+ deep tendon reflexes. Treatment recommendations included continuation of current medication, including Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclophene, and Ketoprofen cream, as well as physical therapy and chiropractic treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription compounded Ketoprofen 20% in PLO Gel, 120 grams between 9/10/13 and 11/21/13: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009).

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

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. They are

primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. The only FDA-approved topical NSAID is diclofenac. As per the clinical notes submitted, there is no evidence of a failure to respond to first-line oral medication prior to initiation of a topical analgesic. Therefore, the patient does not currently meet criteria for the use of a topical analgesic. Based on the clinical information received, the request is non-certified.

1 prescription compounded Cyclophene 5% PLO Gel, 120 grams between 9/10/13/ and 11/21/13: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009).

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

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. As per the clinical notes submitted, there is no evidence of a failure to respond to first-line oral medication prior to initiation of a topical analgesic. Therefore, the patient does not currently meet criteria for the use of a topical analgesic. Based on the clinical information received, the request is non-certified.

1 prescription Synapryn 10mg/1ml oral suspension 500ml between 9/10/13 and 11/21/13: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, and National Guideline Clearinghouse

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the clinical notes submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continued to present with 8-9/10 pain. There was no significant change in the patient's physical examination that would indicate functional improvement. Furthermore, there is no indication that this patient is unable to safely swallow pills or capsules. Based on the clinical information received, the request is non-certified.

1 prescription Tabradol 1mg/ml oral suspension 250ml between 9/10/13 and 11/21/13:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, and National Guideline Clearinghouse

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as non-sedating second-line options for short-term treatment of acute exacerbations in patients with chronic low back pain. However, they show no benefit beyond NSAIDs in pain and overall improvement. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. As per the clinical notes submitted, the patient has continuously utilized this medication. There is no evidence of a satisfactory response to treatment. There is also no documentation of palpable muscle spasm or muscle tension upon physical examination. There is no indication that this patient is unable to safely swallow pills or capsules. Based on the clinical information received, the request is non-certified.

1 prescription Deprizine 15mg/ml oral suspension 250ml between 9/10/13 and 11/21/13:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, and National Guideline Clearinghouse

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: California MTUS Guidelines state proton pump inhibitors are recommended for patients with intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a non-selective NSAID. As per the clinical notes submitted, there is no indication of cardiovascular disease or increased risk factors for gastrointestinal events. There is also no indication that this patient is unable to safely swallow pills or capsules. Based on the clinical information received, the request is non-certified.

1 prescription Dicopanol (diphenhydramine) 5mg/ml oral suspension 150ml between 9/10/13 and 11/21/13: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, and National Guideline Clearinghouse

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Insomnia Treatment

Decision rationale: Official Disability Guidelines state insomnia treatment is recommended based on etiology. Diphenhydramine is an over-the-counter sedating antihistamine which has been suggested for sleep aid. No pharmacologic treatment includes stimulus control, progressive muscle relaxation, and paradoxical intention. As per the clinical notes submitted, there is no indication of chronic insomnia or a chronic condition where an antihistamine is necessary. There is also no evidence that this patient is unable to safely swallow pills or capsules. There is no evidence of a failure to respond to no pharmacologic treatment. Based on the clinical information received, the request is non-certified.

1 prescription Fanatrex (gabapentin) 25mg/ml oral suspension 230ml between 9/10/13 and 11/21/13: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, and National Guideline Clearinghouse

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-18.

Decision rationale: California MTUS Guidelines state anti-epilepsy drugs are recommended for neuropathic pain. Gabapentin is recommended for treatment of diabetic painful neuropathy and postherpetic neuralgia. It is also considered first-line treatment for neuropathic pain. As per the clinical notes submitted, the patient has continuously utilized this medication. Despite the ongoing use, the patient continued to report high levels of pain. Satisfactory response to treatment was not indicated. Furthermore, there is no indication that this patient is unable to safely swallow pills or capsules. Based on the clinical information received, the request is non-certified.

Unknown frequency, amount and duration of physical therapy between 9/10/13 and 11/21/13: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

Decision rationale: California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Guidelines allow for a fading of treatment frequency plus active self-directed home physical medicine. As per the clinical notes submitted, the patient has previously attended physical therapy. There is no

documentation of the previous course of treatment with duration and efficacy. Additionally, it is noted on numerous occasions, the provider documents a lack of response to conservative treatment. Based on the clinical information received, the request is non-certified.

Unknown frequency, amount and duration of chiropractic treatment between 9/10/13 and 11/21/13: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

Decision rationale: California MTUS Guidelines state manual therapy and manipulation is recommended if caused by a musculoskeletal condition. Treatment for the low back is recommended as an option with a therapeutic trial of 6 visits over 2 weeks. As per the clinical notes submitted, the patient has completed a course of chiropractic treatment. Documentation of the previous course of therapy with treatment duration and efficacy was not provided for review. Therefore, ongoing treatment cannot be determined as medically appropriate. As such, the request is non-certified.

Unknown frequency, amount and duration of acupuncture between 9/10/13 and 11/21/13: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: California MTUS Guidelines state acupuncture is used as an option when pain medication is reduced or not tolerated, and may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The time to produce functional improvement includes 3 to 6 treatments with a frequency of 1 to 3 times per week. As per the clinical notes submitted, the patient has previously attended a course of acupuncture treatment. Documentation of the previous course of therapy with treatment duration and efficacy was not provided for review. Therefore, ongoing treatment cannot be determined as medically appropriate. As such, the request is non-certified.