

Case Number:	CM13-0040293		
Date Assigned:	12/20/2013	Date of Injury:	04/16/2012
Decision Date:	02/28/2014	UR Denial Date:	10/02/2013
Priority:	Standard	Application Received:	10/29/2013

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 & Rehabilitation and is licensed to practice in New York and Texas. 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. 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:

This is a 25 year old female who reportedly had an industrial injury 04/16/2012 resulting in chronic mid low back pain. Conservative care reported thus far has been pain medications, 6 prior chiropractic sessions, unspecified number of physical sessions, electrodiagnostic testing on 07/13/2012 which revealed right L5 denervation, and an MRI performed on 05/11/2012 which revealed 5mm broad based protrusion at L4-5 with associated mild to moderate central stenosis. On 08/28/2013, the patient reported persistent low back pain at 6/10, radiating to bilateral lower extremities. Also reported was decreased sensation to the bilateral lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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 Chapter, MRI.

Decision rationale: Official Disability Guidelines note repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings

suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). The information provided noted the patient underwent a prior MRI of the lumbar spine in May of 2012 which was diagnostic in nature and would corroborate with the patient's examination findings. The clinical information submitted for review did not reveal new or progressive neurological deficits on examination to support the necessity of additional imaging at this time. As such, the requested service is non-certified.

MRI thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

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 Chapter, MRI.

Decision rationale: Official Disability Guidelines note repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). The information provided noted the patient underwent a prior MRI of the lumbar spine in May of 2012 which was diagnostic in nature and would corroborate with the patient's examination findings. The clinical information submitted for review did not reveal new or progressive neurological deficits on examination to support the necessity of additional imaging at this time. As such, the requested service is non-certified.

Compound Ketoprofen 20% (120gm): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 112.

Decision rationale: CA MTUS Guidelines state Ketoprofen is not currently FDA approved for a topical application as it has an extremely high incidence of photocontact dermatitis. Given the lack of guideline support and lack of extenuating circumstances provided in the documentation to support approving outside of guideline recommendations, the request is non-certified.

Compound cyclophene 5% (120gm): Upheld

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

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

Decision rationale: The CA MTUS states there is no evidence for use of any other muscle relaxant as a topical product. The requested medication is a muscle relaxant. Given the lack of guideline support and lack of extenuating circumstances provided in the documentation to support approving outside of guideline recommendations, the request is non-certified.

Synapryn 10mg/1ml (500ml): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment.

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

Decision rationale: Synapryn is Tramadol HCl in oral suspension with glucosamine. The CA MTUS states there should be ongoing documentation of the 4A's addressing pain relief, improvement in activities of daily living, side effects and aberrant behavior. The clinical information submitted for review did not adequately address the 4A's. Although the information states the patient reports medications do offer her temporary relief of the pain and improve her ability to have a restful sleep, it fails to document VAS scores supporting adequate pain relief with this medication and failed to address objective functional improvement to support continuation of this medication. As such, the request is non-certified.

Tabradol 1mg/ml (250ml): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain Page(s): 41.

Decision rationale: The requested Tabradol contains cyclobenzaprine or Flexeril. The CA MTUS states that cyclobenzaprine is recommended as an option, using a short course of therapy and treatment should be brief. The clinical information submitted revealed the patient has been on this medication for an extended period of time which would exceed guideline recommendations. Also, the patient was not noted to have objective functional improvement as a result of this medication. As such, the request is non-certified.

Dicopanol 5mg/ml (150ml): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 113.

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, Insomnia Treatment.

Decision rationale: Dicopanol is Benadryl. Official Disability Guidelines state pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. The clinical information submitted did not provide evidence that an evaluation of potential causes of sleep disturbances had been performed to support utilizing pharmacological agents. While the patient is reported to indicate the medications help provide her with a more restful sleep, this was not quantified with the number of hours the patient is able to sleep with this medication as opposed to without. As such, the request is non-certified.

Fanatrex 25mg/ml (420ml): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain Page(s): 49.

Decision rationale: The requested medication of Fanatrex is gabapentin. CA MTUS states 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 clinical information provided did not objective support the efficacy of this medication to support continuation. As such, the request is non-certified.

Deprizine 15mg/ml (250ml): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 113.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Drugs.com

Decision rationale: The requested Deprizine is ranitidine hydrochloride. This medication is used for treating or preventing heartburn, acid indigestion, and sour stomach caused by certain food and drinks. The clinical information provided did not indicate the patient had any GI side effects or symptoms to support the use of this medication. As such, the request is non-certified.

DME hot/cold unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 69.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

Decision rationale: The CA MTUS/ACOEM states at-home application of cold in the first few days of an acute complaint is recommended; thereafter, applications of heat or cold. The clinical

information submitted for review did not reveal the patient had tried at-home applications of heat/cold that were not efficacious to support the requested DME Unit. As such, the request is non-certified.