

Case Number:	CM13-0040598		
Date Assigned:	12/20/2013	Date of Injury:	11/02/2011
Decision Date:	02/19/2014	UR Denial Date:	10/23/2013
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 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:

The patient is a 39-year-old male who reported an injury on 11/02/2011 after lifting a heavy object which caused injury to the low back. The patient's treatment history included medication usage and a lumbar fusion. The patient's chronic pain was managed by physical therapy and medications. The patient was monitored for aberrant behavior with urine drug screens. The patient underwent an MRI that revealed a disc herniation at the L2-3 and L5-S1 levels with bilateral neural foraminal and spinal canal stenosis. Posterior spinal fusion changes were also noted at the L3-4 and L4-5 levels with a sacralized L5 vertebral body. The patient's most recent clinical exam findings included well healed surgical incision consistent with prior lumbar fusion surgery, an inability to heel/toe walk, tenderness to the bilateral paraspinal musculature, positive straight leg raising test bilaterally at 25 degrees, and decreased sensation of the bilateral lower extremities with decreased motor strength rated at a 3/5 of the bilateral lower extremities. The patient's diagnoses included status post lumbar fusion, lumbar disc herniation, deformity of the lumbar spine, and lumbar radiculopathy. The patient's treatment plan included continuation of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Compounded ketoprofen gel, 20% 120 gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain- Topical Analgesics, Ketoprofen Page(s): 112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The compounded ketoprofen gel 20% 100 g is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration. The California Medical Treatment Utilization Schedule does not recommend the use of ketoprofen as a topical analgesic as it is not an FDA approved topical formulation. Additionally, the documentation submitted for review does not provide any evidence of significant quantitative pain relief or definitive functional benefit as a result of the patient's medication schedule. Therefore, continued use would not be indicated. As such, the requested compound for ketoprofen gel 20% 120 g is not medically necessary or appropriate.

Compounded cyclophene 5% gel 120 gm: 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 clinical documentation submitted for review does provide evidence that the patient has been using this medication for an extended duration of time. However, the California Medical Treatment Utilization Schedule does not recommend the use of muscle relaxants as a topical agent as there is little scientific data to support the efficacy of this type of medication as a topical agent. Additionally, the clinical documentation does not include a quantitative pain assessment or definitive functional benefit as the result of medication usage. As such, the requested compound cyclophene 5% gel 120 g is not medically necessary or appropriate.

Synapryn 10gm/1ml; 500 ml: 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 Chronic Pain Medical Treatment Guidelines Opioids On-Going Management and Glucosamine and Medica.

Decision rationale: The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration of time. The requested medication is a compounded liquid medication containing tramadol and glucosamine. The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of a patient's chronic pain be supported by documentation of a quantitative pain assessment, definitive functional benefit, managed side effects, and evidence of monitoring for

aberrant behavior. The clinical documentation submitted for review does provide evidence that the patient does undergo regular urine drug screens with no documented symptoms related to aberrant behavior. However, the clinical documentation fails to provide a quantitative pain assessment and documentation of functional benefit to support continued use. The requested medication also contains glucosamine. This California Medical Treatment Utilization Schedule does recommend the use of glucosamine for patients with osteoarthritic pain. The clinical documentation submitted for review does not provide any evidence that the patient's pain complaints are related to osteoarthritis. Additionally, the California Medical Treatment Utilization Schedule recommends medications used for chronic pain are introduced 1 at a time to establish efficacy of each medication. Therefore, a compounded medication would not be supported. As such, the request for Synapryn 10 g/1 mL; 500 mL is not medically necessary or appropriate.

Tabradol 1mg/ml, 250 ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Muscle Relaxants Page(s): 63.

Decision rationale: The requested medication Tabradol contains Cyclobenzaprine. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration of time. The California Medical Treatment Utilization Schedule does not recommend use of muscle relaxants for an extended duration. Only short courses of treatment are supported by guideline recommendations. The clinical documentation submitted for review does indicate that the patient has been on this medication for an extended period of time and continued use would not be indicated. As such, the request for Tabradol 1 mg/mL, 250 mL is not medically necessary or appropriate.

Deprizine 15mg/ml, 250 ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain- Medical Food.. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 9th Edition (Web), 2011

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68.

Decision rationale: The requested medication contains Ranitidine. The California Medical Treatment Utilization Schedule recommends gastrointestinal protectants for patients who are at risk for developing gastrointestinal disturbances related to medication usage. The clinical documentation submitted for review does provide evidence that the patient has been using medications for pain control for an extended duration of time. However, the most recent clinical documentation does not contain an adequate assessment of the patient's gastrointestinal system to support that the patient is at risk for developing gastrointestinal disturbances related to

medication usage. Therefore, continued use of this medication would not be supported by guideline recommendations. As such, the requested Deprezine 15 mg/mL 250 mL is not medically necessary or appropriate.

Dicopanol 5mg/ml; 150 ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain- Medical food.. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 9th Edition (Web), 2011

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Pain Chapter, Diphenhydramine (Benadryl).

Decision rationale: The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration of time. Official Disability Guidelines do not recommend sedating antihistamines for long-term insomnia treatment. Additionally, the clinical documentation submitted for review fails to provide an adequate assessment of the patient's sleep hygiene to support continued use. As such, the requested Dicopanol 5 mg/mL; 150 mL is not medically necessary or appropriate.

Fanatrex 25mg/ml, 420 ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain- Gabapentin Page(s): 16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Antiepilepsy Drugs (AEDs) Page(s): 16.

Decision rationale: The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration of time. The requested medication does contain gabapentin. The California Medical Treatment Utilization Schedule recommends the continued use of antiepileptic drugs to be supported by documentation of symptom relief and evidence of increased functional benefit. The clinical documentation submitted for review does not provide any evidence that the patient has significant symptom relief or significant functional benefit related to his medication. Therefore, continued use would not be supported by guideline recommendations. As such, the requested Fanatrex 25 mg/mL, 420 mL is not medically necessary or appropriate.

Urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Treatment Guidelines, Page(s): 77.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Drug Testing Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Urine Drug Screens.

Decision rationale: California Medical Treatment Utilization Schedule recommends urine drug screening when there is suspicion of illicit drug use or nonadherent behavior to the patient's prescribed medication schedule. The clinical documentation submitted for review does not provide any evidence that the patient has symptoms to support suspicion of illicit drug use. Official Disability Guidelines recommend patients with low risk of aberrant behavior be monitored on a yearly basis with urine drug screens. The clinical documentation submitted for review does provide evidence that the patient recently submitted to a urine drug screen that was consistent with the patient's prescribed medication schedule. As there is no documentation that the patient is at moderate to high risk for aberrant behavior, additional urine drug screens would not be supported. As such, the requested urine drug screen is not medically necessary or appropriate.

EMG of bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 61.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The American College of Occupational and Environmental Medicine recommends EMGs when radiculopathy is not clinically evident. The clinical documentation submitted for review does provide clinical evidence that the patient's pain is radicular in nature. The patient has decreased motor strength in the bilateral lower extremities, disturbed sensation in the bilateral lower extremities, and a positive straight leg raising test bilaterally. Therefore, an EMG of the bilateral lower extremities would not be indicated. As such, the requested EMG of the bilateral lower extremities is not medically necessary or appropriate.

NCV of bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 61.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Nerve Conduction Studies (NCS).

Decision rationale: Official Disability Guidelines do not recommend the use of an NCV when radiculopathy is clinically evident. The clinical examination revealed a positive bilateral straight leg raising test, decreased motor strength in the bilateral lower extremities, and decreased sensation in the bilateral lower extremities. As radiculopathy is clinically evident upon physical examination, an NCV would not be indicated. As such, the requested NCV of the bilateral lower extremities is not medically necessary or appropriate.

Acupuncture of the lumbar spine, QTY 18: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The clinical documentation submitted for review does provide evidence that the patient previously received acupuncture of the lumbar spine. The California Medical Treatment Utilization Schedule recommends continued use of acupuncture as a treatment modality is based on documentation of functional benefits and symptom response. The clinical documentation submitted for review does not provide any evidence that the patient had a positive response to prior treatments. There is no documentation that prior acupuncture treatments provided significant functional benefit or a decrease in medication usage. As such, the requested acupuncture of the lumbar spine, quantity 18 is not medically necessary or appropriate.