

Case Number:	CM14-0136799		
Date Assigned:	09/29/2014	Date of Injury:	05/03/2012
Decision Date:	11/04/2014	UR Denial Date:	07/31/2014
Priority:	Standard	Application Received:	08/25/2014

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 Anesthesiology and Pain Medicine and is licensed to practice in Florida. 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 injured worker is a 45-year-old male who reported an injury on 05/02/2012. The mechanism of injury was not submitted for clinical review. The diagnoses included lumbosacral sciatica syndrome, lumbar spine herniated nucleus pulposus, lumbar region spinal canal stenosis, low back pain, lumbar radiculopathy, bilateral knee medial meniscal tear, right knee joint effusion, and left ankle sprain/strain. Previous treatments included medication and surgery. Within the clinical note dated 10/07/2014 it was reported the injured worker complained of low back pain. He described the pain as burning radicular pain. He rated his pain 6/10 in severity. Upon the physical examination the provider noted the injured worker had tenderness to palpation of the bilateral posterior superior iliac spine. Range of motion was noted to be flexion at 35 degrees and extension at 15 degrees. There was tenderness to palpation over the medial and lateral joint line at the left knee. There was tenderness to palpation of the lateral joint line of the right knee. The provider requested Terocin patches, LINT sessions, Ketoprofen cream, Cyclophene cream, Dicopanol, Deprizine, Fanatrex, Synapryn, Tabradol, and a urine drug screen. However, a rationale was not submitted for clinical review. The Request for Authorization was submitted and dated 09/12/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Unknown prescription for Terocin patches: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Compounded products; Terocin patches.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112..

Decision rationale: The request for Unknown prescription for Terocin patches is not medically necessary. The California MTUS Guidelines note topical NSAIDs are recommended for osteoarthritis and tendinitis, in particular that of the knee and/or elbow, and other joints that amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. There is a lack of documentation indicating the medication had been providing objective functional benefit and improvement. The request submitted failed to provide the frequency, quantity, and treatment site. Therefore, the request is not medically necessary.

6 localized intense neurostimulation therapy (LINT): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar and Thoracic (Acute and Chronic)

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, Localized high-intensity neurostimulation

Decision rationale: The request for 6 LINT sessions is not medically necessary. The Official Disability Guidelines state LINT therapy is not recommended until there are higher quality studies. Initial results are promising, but only from 2 low quality studies sponsored by manufacturers. Localized manual high intensity neurostimulation devices are applied to small surface areas to stimulate peripheral nerve endings, thus causing the release of endogenous endorphins. This procedure is usually described as hyper stimulation analgesia, and has been investigated in several controlled studies. However, such treatments are time consuming and cumbersome, and require previous knowledge of localized and peripheral nerve endings responsible for low back pain or manual impeding mapping of the back, and these locations prevent their extensive utilization. There is a lack of documentation warranting the medical necessity for the request. The request submitted failed to provide a treatment site. Additionally, the guidelines do not recommend the use of LINT therapy. Therefore, the request is not medically necessary.

Unknown prescripion for topical compound Ketoprofen cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs - regarding Ketoprofen.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112.

Decision rationale: The request for Unknown prescription for topical compound Ketoprofen cream is not medically necessary. The California MTUS Guidelines note topical NSAIDs are recommended for osteoarthritis and tendinitis, in particular that of the knee and/or elbow, and other joints that amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. Ketoprofen is a non FDA approved agent for topical application. It has an extremely high incidence of photo contact dermatitis. There is a lack of documentation warranting the medical necessity for the request. The clinical documentation failed to provide the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency, dosage, and treatment site of the medication. Therefore, the request is not medically necessary.

1 prescription for topical compound Cyclophene 5% cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Compounded; regarding Cyclophene.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112.

Decision rationale: The request for 1 prescription for topical compound Cyclophene 5% cream is not medically necessary. The California MTUS Guidelines recommend topical NSAIDs osteoarthritis and tendinitis, in particular that of the knee and/or elbow, and other joints that amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the request submitted failed to provide the treatment site. Therefore, the request is not medically necessary.

1 prescription for Dicopanol 5mg: Upheld

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) Pain, Insomnia Treatment

Decision rationale: The request for 1 prescription for Dicopanol 5mg is not medically necessary. The Official Disability Guidelines note sedating antihistamines have been suggested for sleep aids, including Dicopanol. Tolerance seems to develop within a few days. Next day sedation has been noted, as well as impaired psychomotor and cognitive function. There is a lack of documentation indicating the medication had been providing objective functional benefit and improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

1 prescription for Deprizine 5mg: 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 NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 66-67.

Decision rationale: The request for 1 prescription for Deprizine 5mg is not medically necessary. The California MTUS Guidelines recommend non-steroidal anti-inflammatory drugs at the lowest dose for the shortest period of time. The guidelines note NSAIDs are recommended for the signs and symptoms of osteoarthritis. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

1 prescription for Fanatrex 25mg: 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 Gabapentin Page(s): 49.

Decision rationale: The prescription for Fanatrex 25mg is not medically necessary. The California MTUS Guidelines note Gabapentin has been shown to be effective for the treatment of diabetic painful neuropathy and post-herpetic neuralgia, and has been considered a first line treatment for neuropathic pain. There is a lack of documentation indicating the medication had been providing objective functional benefit and improvement. The request submitted failed to provide the frequency of the medication. Additionally, there is no clinical documentation indicating the injured worker was treated for diabetic painful neuropathy or post-herpetic neuralgia. Therefore, the request is not medically necessary.

1 prescription for Synapryn 10mg: 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 Opioids, criteria for use, On-Going Management Page(s): 78.

Decision rationale: The request for Synapryn 10mg is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the

medication. Additionally, the provider failed to document an adequate and complete pain assessment. Therefore, the request is not medically necessary.

1 prescription for Tabradol 1mg: 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 Muscle Relaxants Page(s): 63 and 64.

Decision rationale: The request for Tabradol 1mg is not medically necessary. The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbations in patients with chronic low back pain. The guidelines note the medication is not recommended to be used for longer than 2 to 3 weeks. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

1 urine drug screen: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic); Regarding Urine Drug Testing

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Test Page(s): 43.

Decision rationale: The request for 1 urine drug screen is not medically necessary. The California MTUS Guidelines recommend a urine drug screen test as an option to assess for the use or the presence of illegal drugs. It may also be used in conjunction with a therapy trial of opioids, for ongoing management, and as a screening for risk of misuse and addiction. The documentation provided did not indicate the injured worker had any aberrant behaviors, drug seeking behaviors, or whether the injured worker was suspected of illegal drug use. Although a urine drug screen would be appropriate for individuals on opioids, a urine drug screen after the initial baseline would not be recommended unless there is significant documentation of aberrant drug taking behaviors. Therefore, the request is not medically necessary.