

Case Number:	CM14-0020273		
Date Assigned:	04/25/2014	Date of Injury:	10/23/2011
Decision Date:	07/23/2014	UR Denial Date:	01/28/2014
Priority:	Standard	Application Received:	02/18/2014

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, has a subspecialty in 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 51 year old male who reported an injury on 04/16/2011. The mechanism of injury was not provided in the clinical documentation. The clinical note dated 03/05/2014 reported the injured worker complained of burning, radicular low back pain, muscle spasms, rated pain 9/10 and constant. The injured worker also complained of right knee pain with muscles spasms and reported constant pain rated 9/10 with weakness in the right leg which with giving out. The injured worker reported the symptoms persisted but the medication offered temporary relief of pain and improved her ability to sleep. The physical exam indicated the injured worker ambulated with a cane. There was also tenderness to palpation at the bilateral lumbar paraspinal muscles and both PSIS. The provider also documented the injured worker had a positive Tripod sign and Flip test. The provider noted the injured worker had right knee 1+ edema with tenderness at the medial/lateral joint line with a positive McMurray's test and with no ligament instability. The injured worker was awaiting consultation with an orthopedic surgeon regarding the right knee meniscal tear. The injured worker was also awaiting consultation with a pain management specialist regarding the epidural steroid injection for the lumbar spine. The provider recommended the injured worker continue with physical therapy as well as acupuncture therapy treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-RAY SERIES OF THE LUMBAR SPINE (6 VIEWS: FLEXION, EXTENSION, AP, LATERAL, 2 OBLIQUE): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

Decision rationale: The request for x-ray series of the lumbar spine (6 views: flexion, extension, ap, lateral, 2 oblique) is non-certified. The injured worker complained of constant, burning, radicular low back pain rated 9/10, and muscle spasms. The injured worker also complained of constant right knee pain rated 9/10 with muscles spasms, weakness, and giving out. The injured worker reported her symptoms persisted; however, her medication offered temporary relief of pain and improved her ability to sleep. The American College of Occupational and Environmental Medicine recommend x-rays of the lumbar spine when red flags for fracture are presents, and or for cancer or infection are present. The guidelines do not recommend x-rays for routine use during the first month of symptoms in absence of red flags. There is a lack of documentation indicating the injured worker to have a fracture or red flag of infection or cancer. Therefore the request for x-ray series of the lumbar spine (6 views: flexion, extension, AP, lateral, 2 oblique) is non-certified.

X-RAY SERIES OF THE RIGHT KNEE, 3 VIEWS: AP, LATERAL, SUNRISE): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 346-347.

Decision rationale: The request for x-ray series of the right knee, 3 views: AP, lateral, sunrise is non-certified. The injured worker complained of constant, burning, radicular low back pain rated 9/10, and muscle spasms. The injured worker also complained of constant right knee pain rated 9/10 with muscles spasms, weakness, and giving out. The injured worker reported her symptoms persisted; however, her medication offered temporary relief of pain and improved her ability to sleep. The American College of Occupational and Environmental Medicine recommend plain film x-rays for suspected red flags. The guidelines also note they do not recommend x-rays for routine use of most knee complaints or injuries. There is a lack of documentation indicating the injured worker to have the inability to bear weight, or twisting of the knee or a fracture. The requesting physician's rationale for the request was unclear. Therefore, the request for x-ray series of the right knee, 3 views: AP, lateral, sunrise is non-certified.

SHOCKWAVE THERAPY SESSIONS, #3: 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) Knee & Leg (Acute & Chronic), Extracorporeal shock wave therapy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Extracorporeal shock wave therapy.

Decision rationale: The injured worker complained of constant, burning, radicular low back pain rated 9/10, and muscle spasms. The injured worker also complained of constant right knee pain rated 9/10 with muscles spasms, weakness, and giving out. The injured worker reported her symptoms persisted; however, her medication offered temporary relief of pain and improved her ability to sleep. The ACOEM states some medium quality evidence supports high energy extracorporeal shock wave therapy for calcifying tendinitis of the shoulder. The Official Disability Guidelines recommend shockwave therapy for calcifying tendinitis but not for other shoulder disorders. The guidelines also not injured workers whose pain from calcifying tendinitis of the shoulder has remained despite six months of standard treatment. The guidelines also recommend injured workers should undergo at least 3 conservative treatments prior to the use of shockwave therapy. The site at which the requested therapy is to be performed was unclear within the request. It did not appear the injured worker has a diagnosis of calcifying tendonitis. The requesting physician's rationale for the request was unclear. There is a lack of documentation indicating the medical necessity of the use of a 3 shock wave therapy sessions therefore it is not medically necessary.

KETOPROFEN 20% IN PLO GEL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: The request for ketoprofen 20% in plo gel is non-certified. The injured worker complained of constant, burning, radicular low back pain rated 9/10, and muscle spasms. The injured worker also complained of constant right knee pain rated 9/10 with muscles spasms, weakness, and giving out. The injured worker reported her symptoms persisted; however, her medication offered temporary relief of pain and improved her ability to sleep. The California MTUS guidelines note that Ketoprofen is largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines note topical NSAIDs are recommended for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. There was a lack of objective findings indicating the injured worker had osteoarthritis or tendinitis. The rationale for the physicians request was unclear. Furthermore, the request does not include the quantity of the proposed medication. Therefore, ketoprofen 20% in plo gel is non-certified.

CYCLOPHENE 5% IN PLO GEL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: The request for Cyclophene 5% in plo gel is non-certified. The injured worker complained of constant, burning, radicular low back pain rated 9/10, and muscle spasms. The injured worker also complained of constant right knee pain rated 9/10 with muscles spasms, weakness, and giving out. The injured worker reported her symptoms persisted; however, her medication offered temporary relief of pain and improved her ability to sleep. The California MTUS guidelines note topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines note there is no evidence for the use of muscle relaxants for topical application. There was a lack of objective findings indicating the medical necessity for the use of the requested medication. Additionally, the guidelines do not recommend the use of muscle relaxants for topical application. Furthermore, the request does not include the quantity of the proposed medication. Therefore the request for Cyclophene 5% in Plo gel is non-certified.

DICOPANOL 5MG/ML ORAL SUSPENSION 150ML: 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) Pain (chronic), Compound drugs.

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

Decision rationale: The request for Dicopanol 5MG/ML oral suspension 150 ML is non-certified. The injured worker complained of constant, burning, radicular low back pain rated 9/10, and muscle spasms. The injured worker also complained of constant right knee pain rated 9/10 with muscles spasms, weakness, and giving out. The injured worker reported her symptoms persisted; however, her medication offered temporary relief of pain and improved her ability to sleep. Per the provided documentation Dicopanol contains diphenhydramine and other proprietary ingredients; it appears the provider is recommending the medication for insomnia. The guidelines also note sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine). There is a lack of objective findings indicating the need for the requested medication. Therefore, the request for Dicopanol 5MG/ML oral suspension 150 ML is non-certified.

DEPRIZINE 5MG/ML ORAL SUSPENSION 250ML: 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 NSAID, GI symptoms & cardiovascular risks Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound Drugs.

Decision rationale: The request for deprizine 5mg/ml oral suspension 250ml is non-certified. The injured worker complained of constant, burning, radicular low back pain rated 9/10, and muscle spasms. The injured worker also complained of constant right knee pain rated 9/10 with muscles spasms, weakness, and giving out. The injured worker reported her symptoms persisted; however, her medication offered temporary relief of pain and improved her ability to sleep. Deprizine is a ranitidine hydrochloride 16.8 mg/mL (15 mg/mL ranitidine) in an oral suspension. The California MTUS guidelines recommend, for the treatment of dyspepsia secondary to NSAID therapy, injured workers should stop the NSAID, switch to a different NSAID, or consider an H2-receptor antagonist or PPI. The Official Disability guidelines do not recommend deprizine as a first line therapy for most patients. The guidelines also note to include at least one drug substance that is the sole active ingredient in an FDA approved prescription drug not including OTC. There is a lack of documentation of any risk indicating the medical necessity of the medication requested. Additionally the injured worker is not on any NSAID therapy. Therefore, the request for deprizine 5mg/ml oral suspension 250ml is non-certified.

FANATREX 25MG/ML ORAL SUSPENSION 420ML: 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 Antiepilepsy drugs AED Page(s): 16-19. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound Drug.

Decision rationale: The request for fanatrex 25mg/ml oral suspension 420ml is non-certified. The injured worker complained of constant, burning, radicular low back pain rated 9/10, and muscle spasms. The injured worker also complained of constant right knee pain rated 9/10 with muscles spasms, weakness, and giving out. The injured worker reported her symptoms persisted; however, her medication offered temporary relief of pain and improved her ability to sleep. Fanatrex is gabapentin 25mg/mL in an oral suspension. The California MTUS guidelines note Gabapentin 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 guidelines also note that the recommendation for an adequate trial with gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. The Official Disability guidelines note the use of Fanatrex is not recommended as a first line therapy for most patients but recommended as an option after a trial of first line FDA approved drugs. The guidelines also note the medication is to include at least one drug substance that is the sole active ingredient in the FDA approved prescription, not including over the counter drugs. There is a lack of objective findings of neuropathic pain indicating the medical necessity for the continued use of the medication. Therefore, the request for fanatrex 25mg/ml oral suspension 420ml is non-certified.

SYNAPRYN 10MG/1ML ORAL SUSPENSION 500ML: 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 On going management & Glucosamine Page(s): 78-79, 50. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound Drugs.

Decision rationale: The request for Synapryn 10 mg/1 ml oral suspension 500 ml is non-certified. The injured worker complained of constant, burning, radicular low back pain rated 9/10, and muscle spasms. The injured worker also complained of constant right knee pain rated 9/10 with muscles spasms, weakness, and giving out. The injured worker reported her symptoms persisted; however, her medication offered temporary relief of pain and improved her ability to sleep. Synapryn is tramadol hydrochloride 10 mg/mL, in an oral suspension with glucosamine. The California MTUS guidelines for Tramadol note the ongoing review and documentation of pain relief, functional status and appropriate medication use and side effects. The guidelines also recommend the use of a urine drug screen. The California MTUS guidelines for Glucosamine note it is as an option given its low risk in patients with moderate arthritis pain, especially for knee osteoarthritis. The Official Disability guidelines note the use of Fanatrex is not recommended as a first line therapy for most patients but recommended as an option after a trial of first line FDA approved drugs. The guidelines also note the medication is to include at least one drug substance that is the sole active ingredient in the FDA approved prescription, not including over the counter drugs. There is lack of objective findings indicating the injured worker to have arthritic pain. In addition there is a lack of documentation of the use of a urine drug screen or the efficacy indicating the medical necessity of the requested medication. Therefore, the request for Synapryn 10 mg/1 ml oral suspension 500 ml is non-certified.

TABRADOL 1MG/1ML ORAL SUSPENSION 250ML: 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 relaxant Page(s): 64. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound.

Decision rationale: The request for Tabradol 1 mg/1ml oral suspension 250 mg is non-certified. The request for Synapryn 10 mg/1 ml oral suspension 500 ml is non-certified. The injured worker complained of constant, burning, radicular low back pain rated 9/10, and muscle spasms. The injured worker also complained of constant right knee pain rated 9/10 with muscles spasms, weakness, and giving out. The injured worker reported her symptoms persisted; however, her medication offered temporary relief of pain and improved her ability to sleep. Tabradol is a compound drug containing cyclobenzaprine and methysulfonylmethane. The California MTUS guidelines indicate cyclobenzaprine is recommended for a short course of therapy. Limited,

mixed-evidence does not allow for a recommendation for chronic use. The Official Disability guidelines note the use of Fanatrex is not recommended as a first line therapy for most patients but recommended as an option after a trial of first line FDA approved drugs. The guidelines also note the medication is to include at least one drug substance that is the sole active ingredient in the FDA approved prescription, not including over the counter drugs. There is a lack of objective clinical findings indicating the efficacy of the medication. Therefore, the request for Tabradol 1 mg/1ml oral suspension 250 mg is non-certified.