

Case Number:	CM14-0027607		
Date Assigned:	06/13/2014	Date of Injury:	02/21/2012
Decision Date:	07/28/2014	UR Denial Date:	02/04/2014
Priority:	Standard	Application Received:	03/04/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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 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 patient is a 33 year old male with date of injury 2/21/12. The treating physician report dated 1/10/14 indicates that the patient presents with pain affecting the left wrist 8/10, lower back pain 5-7/10 with radiation to the bilateral lower extremities with paresthesia, bilateral knee pain 5-7/10, anxiousness, depression and difficulty sleeping. The current diagnoses are: 1. Left wrist injury 2. Lumbar intervertebral disc displacement 3. Bilateral knee s/s 4. Unspecified mood disorder. The utilization review report dated 2/4/14 denied the request for shockwave therapy left wrist, EMG/NCV upper extremity, Ketoprofen, Cyclophene, Synapryn, Tabradol, Deprizine, Dicopanil and Fanatrex based on lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

SHOCKWAVE THERAPY LEFT HAND/WRIST: 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 ODG Forearm, Wrist and Hand chapter.

Decision rationale: The patient presents with chronic pain affecting the left wrist, lumbar spine, lower extremities, bilateral knees and depression. The current request is for Shockwave therapy

left wrist/hand. The treating physician report dated 1/10/14 states, "The patient is to undergo a course of shockwave therapy, that is, up to 3 treatments for each affected body part. (left wrist, left knee)." The MTUS Guidelines do not address shockwave therapy or Extracorporeal shockwave therapy (ESWT). The ODG Guidelines indicate that ESWT is an option for calcifying tendonitis of the shoulder only and is not recommended for treatment of the knee. The Forearm, Wrist & Hand as well as the Carpal Tunnel Syndrome chapters do not address ESWT for the wrist. The treating physician has not documented any rationale as to why this procedure is being recommended. There is no medical evidence to support the current request. Recommendation is for denial.

(EMG) ELECTROMYOGRAPHY) UPPER EXTREMITY: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Electrodiagnostic Studies (EDS).

Decision rationale: The patient presents with chronic pain affecting the left wrist, lumbar spine, lower extremities, bilateral knees and depression. The current request is for EMG upper extremity. The treating physician report dated 1/10/14 states, "The patient is requested an EMG/NCV study of the bilateral upper and lower extremities. Tinel's wrist positive, Phalen's positive. Motor strength is 4/5 in all the represented muscle groups in the left upper extremity." MTUS does not address EMG/NCV testing. ACOEM page 262 recommends electrodiagnostic studies to help differentiate between CTS and other conditions, such as cervical radiculopathy. Review of the records provided does not show that prior electrodiagnostic studies have been performed. Given the patient's continued numbness and weakness of the left wrist the recommendation is medically necessary.

(NCV) NERVE CONDUCTION VELOCITY) UPPER EXTREMITY: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262.

Decision rationale: The patient presents with chronic pain affecting the left wrist, lumbar spine, lower extremities, bilateral knees and depression. The current request is for nerve conduction velocity upper extremity. The treating physician report dated 1/10/14 states, "The patient is requested an EMG/NCV study of the bilateral upper and lower extremities. Tinel's wrist positive, Phalen's positive. Motor strength is 4/5 in all the represented muscle groups in the left upper extremity." MTUS does not address EMG/NCV testing. ACOEM page 262 recommends electrodiagnostic studies to help differentiate between CTS and other conditions, such as cervical radiculopathy. Review of the records provided does not show that prior electrodiagnostic studies

have been performed. Given the patient's continued numbness and weakness of the left wrist the recommendation is for authorization.

KETOPROFEN 20%: Overturned

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

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

Decision rationale: The patient presents with chronic pain affecting the left wrist, lumbar spine, lower extremities, bilateral knees and depression. The current request is for Ketoprofen 20%. MTUS Guidelines support use of NSAID topicals for peripheral arthritis and tendonitis. The provider in this case has documented chronic knee pain associated with arthritis and bilateral meniscus pain. Recommendation is medically necessary.

CYCLOPHENE 5%: Upheld

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

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

Decision rationale: The patient presents with chronic pain affecting the left wrist, lumbar spine, lower extremities, bilateral knees and depression. The current request is for Cyclophene 5%. The treating physician states that Cyclophene contains cyclobenzaprine hydrochloride and other proprietary ingredients. The MTUS Guidelines do not support any topical analgesics that contain muscle relaxants. MTUS states, "Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product." Recommendation is for denial.

SYNAPRYL 10MG/ML ORAL SUSPENSION: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Synapryn..

Decision rationale: necessary: The patient presents with chronic pain affecting the left wrist, lumbar spine, lower extremities, bilateral knees and depression. The current request is for Synapryn 10mg/ml. Synapryn is an oral suspension that contains tramadol and glucosamine as well as other proprietary ingredients. MTUS in general for compounded medications, page 111 states "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." The "other proprietary ingredients" are not disclosed. Since

components of "other proprietary ingredients" are unknown, they cannot be compared against MTUS criteria, and therefore cannot be confirmed to be in accordance with MTUS. Recommendation is for denial.

TABRADOL 1MG/ML ORAL SUSPENSION: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, Muscle relaxants (for pain), pgs. 63-66.

Decision rationale: The patient presents with chronic pain affecting the left wrist, lumbar spine, lower extremities, bilateral knees and depression. The current request is for Tabradol 1mg/ml. In review of the treating physician report dated 1/10/14 the treater states, "Tabradol contains cyclobenzaprine, methylsulfonmethane and other proprietary ingredients. Though methylsulfonmethane is regarded as a dietary supplement and is regulated by the FDA, it has not been approved for the treatment of osteoarthritis." The MTUS guidelines support the usage of Cyclobenzaprine for a short course of therapy, not longer than 2-3 weeks. The treater in this case has not documented that this medication will be used for 2-3 weeks. MTUS in general for compounded medications, page 111 states "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." The "other proprietary ingredients" are not disclosed. Since components of "other proprietary ingredients" are unknown, they cannot be compared against MTUS criteria, and therefore cannot be confirmed to be in accordance with MTUS. Recommendation is for denial.

DEPRIZINE 15MG/ML ORAL SUSPENSION: 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, GI symptoms & cardiovascular risk Page(s): 69.

Decision rationale: The patient presents with chronic pain affecting the left wrist, lumbar spine, lower extremities, bilateral knees and depression. The current request is for Deprizine 15mg/ml. The treating physician states Deprizine contains Ranitidine (H2 blocker) and other proprietary ingredients. The MTUS Guidelines states, "Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." However, in this patient, the patient does not have dyspepsia with NSAID. The treater is using H2 blocker for prophylaxis. MTUS require documentation of GI risk assessment such as age >64, concurrent use of ASA, anticoagulant, history of peptic ulcer disease, etc., for prophylactic use of PPI. Recommendation is for denial.

DICOPANOL 15MG/ML ORAL SUSPENSION: 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: The patient presents with chronic pain affecting the left wrist, lumbar spine, lower extremities, bilateral knees and depression. The current request is for Dicopanол 15mg/ml. The treater states, "Dicopanол contains diphenhydramine and other proprietary ingredients. Many pharmacological agents currently on the market for the treatment of insomnia include benzodiazepines and non-benzodiazepines hypnotics." MTUS in general for compounded medications, page 111 states "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." The "other proprietary ingredients" are not disclosed. Since components of "other proprietary ingredients" are unknown, they cannot be compared against MTUS criteria, and therefore cannot be confirmed to be in accordance with MTUS. In reviewing the ODG guidelines there is no support of diphenhydramine on a long-term basis for insomnia either. Recommendation is for denial.

FANATREX 25MG/ML ORAL SUSPENSION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 18-19.

Decision rationale: The patient presents with chronic pain affecting the left wrist, lumbar spine, lower extremities, bilateral knees and depression. The current request is for Fanatrex 25mg/ml. This patient is prescribed Fanatrex which contains gabapentin and other proprietary ingredients. This patient does present with radiating symptoms of the lower extremities, and there may be a component of radicular symptoms or neuropathic pain. The use of gabapentin is appropriate and consistent with MTUS Guidelines. However, it is not known why this treater is prescribing an oral suspension of this medication. There are no documentations in the progress report that the patient has any problems that would preclude use of oral pill medications. Furthermore, Fanatrex contains "other proprietary ingredients" that is not disclosed. Without knowing what is contained in these medications, it cannot be considered for authorization. Recommendation is for denial.