MAXIMUS Federal Services

Case Number:	CM14-0131449		
Date Assigned:	09/16/2014	Date of Injury:	02/20/2009
Decision Date:	09/22/2015	UR Denial Date:	08/05/2014
Priority:	Standard	Application Received:	08/18/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California, Arizona
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 49 year old male, who sustained an industrial injury on 2/20/09. The diagnoses have included low back pain, lumbar spine disc displacement, lumbar spine degenerative disc disease (DDD) and lumbar radiculopathy. Treatment to date has included medications, activity modifications, off work, diagnostics, shockwave therapy, physical therapy, acupuncture, neurostimulation therapy and other modalities. Currently, as per the physician progress note dated 6/24/14, the injured worker complains of burning radicular low back pain that is constant and described as moderate to severe and rated 9/10 on pain scale. The injured worker states that the symptoms persist but the medications offer him temporary relief of pain and improve his ability to have restful sleep. The pain is also alleviated with activity restrictions. The lumbar spine exam reveals pain with toe walking, able to squat to approximately 40 degrees of normal, toe touch to about 8 inches to the ground, ambulates with a cane, tenderness to palpation at the bilateral lumbar paraspinal muscles and spinous processes, straight leg raise positive at 40 degrees bilaterally, decreased range of motion and sensation and motor strength are decreased. The diagnostic testing that was performed included Magnetic Resonance Imaging (MRI) of the lumbar spine dated 12/15/13 reveals disc protrusion, facet hypertrophy, spinal canal narrowing, posterior annular tear/fissure, and there is impingement on the left exiting nerve root. There is straightening of the lumbar lordosis which may be due to myospasm and hemangioma at L4. The current medications included Fanatrex, Dicopanol, Deprizine, Synapryn, Tabradol, and topical compounded creams. The urine drug screen dated 2/25/14, 4/7/14 and 4/29/14 was inconsistent with the medications prescribed and the urine drug screen dated 8/5/14 was

consistent with the medications prescribed. There is no previous therapy sessions noted in the records. The physician requested treatments included 1 prescription of Fanatrex 25mg 420ml, 1 prescription of Dicopanol 5mg 150ml, 1 prescription of Deprizine 15mg 250ml, 1 prescription of Tabradol 1mg 250ml, Synapryn 10mg, 500ml, 1 prescription f topical compound Ketoprofen 20% 165gm, 1 MRI of the lumbar spine, 6 sessions of shockwave therapy and 6 sessions of localized neurostimulation therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Fanatrex 25mg 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 Anti-epileptics for Neuropathic Pain Page(s): 16-21.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that anti-epilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. There should be documentation of pain relief, and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. There is no mention of previous functional response or significant pain response with the use of Fanatrex. Medical necessity has not been substantiated.

1 prescription of Dicopanol 5mg 150ml: 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 chapter, Insomnia.

Decision rationale: ODG notes that sedating anti-histamines have been suggested for sleep aids. Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. The FDA indications for diphenhydramine include use as an antihistaminic, in the management of motion sickness, and parkinsonism, and as a nighttime sleep aid. There is no noted response with regards to sleep, quality of life, and/or function, and frequency was not listed with the request itself. This request is not medically necessary.

1 prescription of Deprizine 15mg 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 H2 blockers, PPIs Page(s): 68-69.

Decision rationale: According to the CA MTUS, Deprizine is an H2 blocker used to treat GERD, and dyspepsia related to NSAID use. There is no mention of any of the above within the submitted documentation, nor is there mention of response with the use of Deprizine. Medical necessity has not yet been established.

1 prescription of Tabradol 1mg 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 Cyclobenzaprine Page(s): 41-42.

Decision rationale: Tabradol contains Cyclobenzaprine, methylsulfonylmethane and other proprietary ingredients. The MTUS states that Cyclobenzaprine treatment should be brief, with a short course of therapy. Additionally, the MTUS states that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. This request is not medically necessary as long-term use is not supported and there is no frequency listed. Tabradol contains Cyclobenzaprine, methylsulfonylmethane and other proprietary ingredients. The MTUS states that Cyclobenzaprine treatment should be brief, with a short course of therapy. Additionally, the MTUS states that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. This request is not supported as long-term use is not supported and there is no frequency listed.

1 prescription of topical compound Ketoprofen 20% 165gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines; regarding Ketoprofen; Topical Analgesics.

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

Decision rationale: Per MTUS guidelines, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anti-convulsants and/or anti- depressants have failed. The guidelines go on to state that when any compounded product contains 1 medication that is not recommended, the compounded product as a whole is not recommended. There is no mention of failure to first line oral agents, nor is there mention of why topical agents are needed over oral agents to treat pain. This request is not medically necessary.

1 MRI of the lumbar spine: Overturned

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): 303.

Decision rationale: Per California MTUS Guidelines, MRI is indicated if there are unequivocal objective findings that identify specific nerve compromise on neurologic examination in patients who do not respond to treatment and who would consider surgery an option. MRI is the mainstay in the evaluation of myelopathy. In addition to diagnosing disc herniation, neoplastic and infectious processes can also be visualized using MRI. The injured worker has failed medications, and has evidence of reduced strength and sensation with positive straight leg raise. MRI in this case can be considered medically necessary.

6 sessions of shockwave therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ESWT section.

Decision rationale: Per guideline criteria, there is no high grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, TENS units, and biofeedback. These palliative tools may be used on a trial basis but should be monitored closely. The ODG note that extracorporeal shock wave therapy is recommended for patients whose pain from calcifying tendinitis of the shoulder has remained despite six months of standard treatment. The ODG states ESWT is not recommended for the lumbar spine, and the CA MTUS do not discuss ESWT for the cervical or lumbar spine. There is no documentation that warrants non-adherence to guideline criteria. Medical necessity has not been substantiated.

6 sessions of localized neurostimulation therapy: 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 LINT section Page(s): 114-117.

Decision rationale: CA MTUS guidelines do support the use of some types of electrical stimulation therapy for the treatment of certain medical disorders. However, regarding LINT specifically, a search of the CA MTUS, ACOEM, ODG, National Library of Medicine, and other

online resources failed to reveal support for its use in the management of cited injuries. Additionally, no documentation was provided identifying that this treatment provides improved outcomes as compared to other treatment options that are evidence-based and supported. There is no support within the submitted documentation to warrant non-adherence to guidelines. As such, this request is not medically necessary.

Synapryn 10mg, 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 Opioids, Criteria for use Page(s): 76-80.

Decision rationale: Synapryn contains Tramadol and Glucosamine, as well as other proprietary ingredients. The criteria for ongoing opiate use is not met within the submitted documentation and as such, this request is not medically necessary.