

Case Number:	CM14-0185959		
Date Assigned:	11/14/2014	Date of Injury:	09/06/2011
Decision Date:	01/16/2015	UR Denial Date:	10/15/2014
Priority:	Standard	Application Received:	11/07/2014

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 Interventional Spine 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 42 year old male with an injury date of 09/06/11. Based on the 09/26/14 progress report provided by treating physician, the patient complains of low back pain rated 6/10. Physical examination to the lumbar spine revealed tenderness to palpation to the lumbar paraspinal muscles and over the lumbosacral junction. Range of motion was decreased, especially on left lateral flexion 15 degrees. Positive straight leg raise test bilaterally. Medications offer temporary relief of pain and improve his ability to have restful sleep. The patient denies problems with the medications. The patient's medications were prescribed in provider reports dated 06/03/14 and 09/26/14, and they include Deprizine (Ranitidine), Dicopanol (Diphenhydramine), Fanatrex (Gabapentin), Synapryn (Tramadol and Glucosamine), Tabradol (Cyclobenzaprine), Cyclobenzaprine, and Ketoprofen cream. Progress reports dated 06/03/14 and 09/26/14 state "periodic UA toxicological evaluation shall be performed," however there are no toxicology reports or discussion available for review. The provider recommended Terocin patches for pain relief, per the progress report dated 06/03/14. The provider stated, "Dicopanol contains Diphenhydramine. It is widely used in many non-prescription sleep aids and cold medications for many years. It has been shown to be safe and effective in the treatment of mild to moderate insomnia." Regarding prescribed medications, the provider provided quotations of usage and indications without discussions pertaining to the patient. 3 shockwave treatment reports dated 07/14/14 - 08/07/14 was provided. The diagnosis dated 09/26/14 included lumbar spine herniated nucleus pulposus and lumbar radiculopathy. The Utilization Review determination being challenged is dated 10/15/14. Treatment reports were provided from 06/03/14 - 10/24/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Terocin Patches: 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)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Lidocaine Page(s): 57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic) Chapter, Lidoderm (Lidocaine patch)

Decision rationale: The request is for Terocin patches. The patient's diagnosis dated 09/26/14 included lumbar spine herniated nucleus pulposus and lumbar radiculopathy. Medications offer temporary relief of pain and improve his ability to have restful sleep. The patient denies problems with the medications. The patient's medications were prescribed in provider reports dated 06/03/14 and 09/26/14, and they included Deprizine (Ranitidine), Dicopanol (Diphenhydramine), Fanatrex (Gabapentin), Synapryn (Tramadol and Glucosamine), Tabradol (Cyclobenzaprine), Cyclobenzaprine, and Ketoprofen cream. 3 shockwave treatment reports dated 07/14/14 - 08/07/14 was provided. MTUS guidelines page 57 states, "topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica)." Page 112 also states, "Lidocaine Indication: Neuropathic pain Recommended for localized peripheral pain." When reading Official Disability Guidelines, it specifies that Lidoderm patches are indicated as a trial if there is "evidence of localized pain that is consistent with a neuropathic etiology." Official Disability Guidelines further requires documentation of the area for treatment, trial of a short-term use with outcome documented for pain and function. The provider recommended Terocin patches for pain relief, per progress report dated 06/03/14. In this case, the patient presents with radicular symptoms and pain in back, but not pain that is peripheral and localized neuropathic. Lidoderm patches would not be indicated based on guidelines. Therefore, this request is not medically necessary.

Ketoprofen 20% 165gm: 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)

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

Decision rationale: The request is for Ketoprofen 20% 165gm. MTUS Chronic Pain Medical Treatment Guidelines has the following regarding topical creams (page 111, chronic pain section): "Topical Analgesics: Non-steroidal anti-inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period." Review of reports do not show documentation

that patient presents with osteoarthritis, nor has the provider indicated what body part would be treated with lotion. Also, NSAID cream is to be used for short duration of 2 weeks. The requested cream is not in line with MTUS indication. Therefore, this request is not medically necessary.

Cyclobenzaprine 5% 100gm: 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)

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

Decision rationale: The request is for Cyclobenzaprine 5% 100GM. The MTUS Chronic Pain Medical Treatment Guidelines has the following regarding topical creams (page 111, chronic pain section): "Topical Analgesics: Recommended as an option as indicated below. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Baclofen: Not recommended. Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product." The provider has not documented what body part will be treated with requested Cyclobenzaprine 5% cream. MTUS page 111 states that if one of the compounded drugs is not recommended, then the entire product is not. In this case, the requested topical compound contains Cyclobenzaprine. Cyclobenzaprine is not supported for topical use per the MTUS guidelines. Therefore, this request is not medically necessary.

Synapryn 10mg/ml 500ml: 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)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 88, 89, 78.

Decision rationale: The request is for Synapryn 10MG/ML 500ML. MTUS Chronic Pain Medical Treatment Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4 A's (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In this case, provider has not stated how Synapryn (Tramadol and Glucosamine) reduces pain and significantly improves patient's activities of daily living; the four A's are not specifically addressed including discussions regarding aberrant drug behavior and specific activities of daily living (ADLs), etc. Given the lack of documentation as required by MTUS, this request is not medically necessary.

Tabradol 1mg/ml 250ml: 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)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

Decision rationale: The request is for Tabradol 1MG/ML 250ML. The MTUS Chronic Pain Medical Treatment Guidelines page 63-66 states: "Muscle relaxants (for pain): Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. The most commonly prescribed antispasmodic agents are Carisoprodol, Cyclobenzaprine, Metaxalone, and Methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy." Guidelines do not suggest use of Cyclobenzaprine for chronic use longer than 2-3 weeks. The patient has been prescribed Tabradol (Cyclobenzaprine) in provider reports dated 06/03/14 and 09/26/14, which is more than 4 months from the Utilization Review decision date of 10/15/14. Therefore, this request is not medically necessary.

Deprizine 5mg/ml 250ml: 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)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risks Page(s): 69.

Decision rationale: The request is for Deprizine 5MG/ML 250ML. Regarding NSAIDs and GI/CV risk factors, MTUS requires determination of risk for GI events including age greater than 65; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; or high dose/multiple NSAID. MTUS Chronic Pain Medical Treatment Guidelines page 69 states "NSAIDs, GI symptoms and cardiovascular risk: Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." In this case, the patient is not on oral NSAIDs to consider PPI or H2-receptor antagonists for prophylactic use, and provider has not documented GI assessment. The patient has been prescribed Deprizine in provider reports dated 06/03/14 and 09/26/14. The provider has not discussed how the patient is doing, and why he needs to continue taking this medication. Given the lack of documentation of continued need for this medication, this request is not medically necessary.

Dicopanol 5mg/ml 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)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress Chapter, Diphenhydramine (Benadryl), Insomnia treatment

Decision rationale: The request is for Dicopanol 5MG/ML 150ML. Official Disability Guidelines, Mental Illness & Stress Chapter states: "Diphenhydramine (Benadryl): See Insomnia treatment, where sedating antihistamines are not recommended for long-term insomnia treatment. The AGS updated Beers criteria for inappropriate medication use includes Diphenhydramine. (AGS, 2012) Insomnia treatment: (4) Sedating antihistamines (primarily over-the-counter medications): Sedating antihistamines have been suggested for sleep aids (for example, Diphenhydramine [Benadryl, OTC in U.S.], Promethazine [Phenergan, prescription in U.S., OTC in other countries]). Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. This RCT determined that diphenhydramine has been shown to build tolerance against its sedation effectiveness very quickly, with placebo-like results after a third day of use. (Richardson, 2002) Due to adverse effects, the U.S. National Committee for Quality Assurance (NCQA) has included diphenhydramine in the HEDIS (Healthcare Effectiveness Data and Information) recommended list of high-risk medications to avoid in the elderly. (NCQA, 2012)" The provider stated, "Dicopanol contains Diphenhydramine. It is widely used in many non-prescription sleep aids and cold medications for many years. It has been shown to be safe and effective in the treatment of mild to moderate insomnia." Official Disability Guidelines states that "Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function." The patient has been prescribed Dicopanol in provider reports dated 06/03/14 and 09/26/14. The provider has not discussed insomnia, and why the patient needs to continue taking this medication. Therefore, this request is not medically necessary.

Fanatrex 25mg/ml 420ml: 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)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin, Gabarone, generic available), Medication for chronic pain Page(s): 18, 19.

Decision rationale: The request is for Fanatrex 25MG/ML 420ML. MTUS Chronic Pain Medical Treatment Guidelines has the following regarding Gabapentin on page 18, 19: "Gabapentin (Neurontin, Gabarone, generic available) 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 patient has been prescribed Fanatrex (Gabapentin) in provider reports dated 06/03/14 and 09/26/14. The provider does not discuss efficacy. There is no discussion as to how this medication has been helpful with pain and function. MTUS page 60 require recording of pain and function when medications are used for chronic pain. Furthermore, there is no documentation of neuropathic pain presented in patient. This request does not meet MTUS indications. Therefore, this request is not medically necessary.

Physical Therapy three (3) times per week for six (6) weeks (18 visits): 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)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99.

Decision rationale: The request is for physical therapy three (3) times per week for six (6) weeks (18 visits). MTUS Chronic Pain Medical Treatment Guidelines pages 98, 99 state the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." The medical reports do not discuss treatment history and the provider does not explain why therapy is being requested other than for subjective pain. There is no discussion of flare-up's, new injury or new symptoms warranting additional treatment. Furthermore, the requested 12 sessions exceed what is recommended per MTUS. Therefore, this request is not medically necessary.

Chiropractic treatment three (3) times per week for six (6) weeks (18 visits): 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)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 8, 58-59.

Decision rationale: The request is for chiropractic treatment three (3) times per week for six (6) weeks (18 visits). MTUS Chronic Pain Medical Treatment Guidelines recommends an optional trial of 6 visits over 2 weeks with evidence of objective functional improvement total of up to 18 visits over 6 to 8 weeks. For recurrences/flare-ups, reevaluate treatment success and if return to work is achieved, then 1 to 2 visits every 4 to 6 months. MTUS page 8 also requires that the provider monitor the treatment progress to determine appropriate course of treatments. In this case, chiropractic therapy treatment history is not known. Given that review of current reports make no reference to a recent course of chiropractic, a short course might be reasonable. However, the requested 18 sessions would exceed what is allowed by MTUS for a trial of 3-6 sessions. Furthermore, if the provider intended for continued treatments, there is no documentation of functional improvement as a result of initial trial. Therefore, this request is not medically necessary.