

Case Number:	CM14-0198118		
Date Assigned:	12/22/2014	Date of Injury:	03/31/2006
Decision Date:	01/30/2015	UR Denial Date:	11/15/2014
Priority:	Standard	Application Received:	11/25/2014

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 Family Practice, has a subspecialty in ENTER SUBSPECIALTY 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:

This is a female patient with an injury date of CT 08/2004 - 03/2006 and no narrative description of mechanism of injury noted found within the provided documentation. She is status post micro-laminectomy at L5-S-1. A lumbar MRI dated 04/30/2012 reports recurrent disc is seen at L5-S-1 2 to 3 mm, L4-5 reveals disc dessication with 2 to 3 mm angular bulge and L3-4 reveals disc protrusion, central and foraminal with stenosis. A primary treating follow up visit dated 11/18/2014 described the patient with a left antalgic gait, noted with moderate paraspinal tenderness, and improved lumbar range of motion. She was diagnosed with headache, cervical sprain, thoracic sprain, lumbar sprain, myalgia and myosis, lumbar disc herniation's, lumbar radiculopathy, sprain of unspecified site of shoulder and upper arm, disorders of bursae and tendons in shoulder region, spasm of muscle, anxiety, unspecified sleep disorder and lumbosacral plexus lesions. The plan of care stated no acupuncture or chiropractic therapy at this time, proceed with psych consultation and proceed with pain management. A request for medications ketoprophen, Cyclobenzaprine and synapryn was received 11/18/2014. The Utilization review denied the request on 11/15/2014 as not meeting medical necessity requirements.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 20% cream 165 grams: 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): 111-112.

Decision rationale: According to guidelines topical analgesic 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. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. 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. According to medical records the patient has been using ketoprofen for a prolonged period of time and is not medically necessary.

Cyclobenzaprine 5% cream, 100grams: 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): 111-112.

Decision rationale: According to guidelines topical analgesic 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. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. There is no evidence for use of any other muscle relaxant as a topical product.

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 opioids Page(s): 76-82.

Decision rationale: According to guidelines it states opioids should only be continued if there is functional improvement. It also states chronic use of opioids can lead to dependence and addiction. According to the patient's medical records it does not state the patient has functional improvement with opioid usage and thus is not medically necessary.

Tabradol 1mg/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 Cyclobenzaprine Page(s): 41.

Decision rationale: According to guidelines it states cyclobenzaprine should be used for a short period of time. The patient has been on tabradol for a prolonged period of time and there is no indication why tablet form is not tolerated and thus is not medically necessary.

Deprizine 15mg/ml oral suspension 250ml: 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 Other Medical Treatment Guideline or Medical Evidence: www.drugs.com.

Decision rationale: According to guidelines Deprizine contains Ranitidine - an anti-histamine that reduces stomach acid and may be used for dyspepsia related to NSAID use.. Based on the medical records there is no documentation that the patient has dyspepsia related to NSAID use and thus is not medically necessary.

Dicopanl 5mg/ml oral suspension 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 Other Medical Treatment Guideline or Medical Evidence: www.drugs.com.

Decision rationale: According to guidelines Dicopanl contains diphenhydramine which can be used to treat sleep problems. According to the medical records there is no documentation why oral pills cannot be tolerated and thus is not medically necessary.

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; GABAPENTIN Page(s): 16-17.

Decision rationale: Based on guidelines Gabapentin is recommended for neuropathic pain. There is a lack of expert consensus on the treatment of neuropathic pain in general due to heterogeneous etiologies, symptoms, physical signs and mechanisms. Most randomized controlled trials (RCTs) for the use of this class of medication for neuropathic pain have been directed at postherpetic neuralgia and painful polyneuropathy (with diabetic polyneuropathy being the most common example). There are few RCTs directed at central pain and none for painful radiculopathy. There should be functional improvement. According to medical records there is no documentation of functional improvement and thus is not medically necessary.

18 chiropractic visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299.

Decision rationale: According to guidelines chiropractic manipulation in the acute phases of injury manipulation may enhance patient mobilization. If manipulation does not bring improvement in three to four weeks, it should be stopped and the patient reevaluated. Based on medical records there is no documentation of improvement and thus is not medically necessary.

18 acupuncture visits: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 8-9.

Decision rationale: According to guidelines acupuncture treatments can be continued if there is documentation of improved function. According to the medical records there is no documentation of functional improvement and thus is not medically necessary.

Unknown shockwave therapy 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), Low Back - Lumbar & Thoracic (Acute & Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Shockwave therapy.

Decision rationale: According to guidelines it states shockwave therapy is not used for cervical and lumbar spine complaints and thus is not medically necessary.