

Case Number:	CM14-0210404		
Date Assigned:	02/05/2015	Date of Injury:	05/03/2012
Decision Date:	05/06/2015	UR Denial Date:	11/20/2014
Priority:	Standard	Application Received:	12/15/2014

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: New York

Certification(s)/Specialty: Internal Medicine

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 45 year old male who sustained an industrial injury reported on 5/3/2012. He has reported chronic, radicular, low back pain, and sharp, stabbing, radicular bilateral knee pain. The diagnoses have included: lumbosacral sciatica syndrome; lumbar region spinal canal stenosis and pain; grade II anterolisthesis of lumbar 4 over lumbar 5; lumbar radiculopathy; bilateral knee medial meniscal tear with right knee anterior cruciate ligament tear and joint effusion; mood and sleep disorders; and anxiety. Treatments to date have included consultations; diagnostic imaging studies; physical therapy; chiropractic treatments; shockwave therapy - lumbar and right knee; activity restrictions; and medication management. The work status classification for this injured worker (IW) was noted to be temporarily totally disabled and off work. On 11/20/2014, Utilization Review (UR) non-certified, for medical necessity, the request, made on 11/17/2014, for: consultation with an orthopedic specialist for the bilateral knees; a urine drug screen; Terocin patches; 6 sessions with localized intense neuro-stimulation therapy (LINT) for the lumbar spine; Depirzine; Dicopanol; Fanatrex; Synapryn; Tabradol; Cyclobenzaprine; and topical compound Ketoprofen cream. The Official Disability Guidelines, chronic knee pain, anterior cruciate ligament reconstruction, indication for surgery, localized manual high-intensity neuro-stimulation devices; and the Medical Treatment Utilization Schedule, chronic pain medical management, topical compounds, urine drug testing; as well as American College of Occupational and Environmental Medicine and National Guideline Clearinghouse, were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 consultation with orthopedic specialist: Overturned

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 Not specific. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Office Visits.

Decision rationale: Per Guidelines, the value of patient/doctor interventions has not been questioned. The need for a clinical office visit with a health care provider is individualized upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. Guidelines state that a set number of office visits per condition cannot be reasonably established as patient conditions vary. The injured worker is diagnosed with Bilateral Knee Medial Meniscal Tear and reports no significant improvement in function with treatment modalities provided to date. Orthopedic consult for further evaluation and treatment is reasonable and medically appropriate. Per guidelines, the request for 1 consultation with orthopedic specialist is medically necessary.

1 PRP treatment for the left knee: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Not addressed. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter.

Decision rationale: Per ODG, Platelet-rich-plasma (PRP) therapy represents a novel noninvasive treatment method for patients with acute or chronic soft-tissue musculoskeletal injuries, but it remains under study. ODG states that the clinical results are encouraging, but inconsistent, and there is a need for further basic-science investigation, as well as randomized, controlled trials to identify the benefits, side effects, and adverse effects that may be associated with the use of PRP for muscular and tendinous injuries. As per guidelines, further clarification of indications and time frame is needed to support the necessity or indication of PRP. The request for 1 PRP treatment for the left knee is not medically necessary.

1 urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, differentiation: dependence & addiction Page(s): 85. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids, Urine drug tests.

Decision rationale: MTUS recommends screening patients to differentiate between dependence and addiction to opioids. Frequency of urine drug testing should be based on documented evidence of risk stratification. Patients at "low risk" of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. Random collection is recommended. Documentation supports that the injured worker is at low risk of addiction or aberrant behavior and there is documentation of recent urine drug screen that is consistent with prescribed medications. Per guidelines, the injured worker should be tested yearly thereafter. The request for 1 urine drug screen is not medically necessary.

Unknown prescription of Terocin patches: 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.

Decision rationale: MTUS states that use of topical analgesics is 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. Terocin is a topical analgesic containing Lidocaine and Menthol. MTUS provides no evidence recommending the use of topical Menthol. Per guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended. The request for Terocin is not medically necessary.

6 sessions of LINT for the lumbar spine: 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 - Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Not Addressed. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Hyperstimulation Analgesia.

Decision rationale: ODG states that Localized intense Neurostimulating therapy (LINT), a procedure, usually described as hyperstimulation analgesia, has been investigated in several controlled studies, but is not recommended until there are higher quality studies. Localized manual high-intensity neurostimulation devices are used to apply localized, intense, low-rate electrical pulses to painful active myofascial trigger points. The request for 6 sessions of LINT for the lumbar spine is not medically necessary due to lack of sufficient evidence to recommend its use as per ODG.

Unknown prescription of Deprizine: 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 Not addressed. Decision based on Non-MTUS Citation <http://www.drugs.com/pro/deprizine.html>.

Decision rationale: Deprizine is a compounding kit for oral suspension of Ranitidine. Documentation fails to provide support that the injured worker has a condition that would require an oral suspension of this medication and established guidelines do not support the use of Deprizine. The request for Deprizine is not medically necessary.

Unknown prescription of Dicopanol: 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 Not Addressed. Decision based on Non-MTUS Citation <http://dailymed.nlm.nih.gov>.

Decision rationale: Dicopanol is a compounded version of Diphenhydramine. Documentation fails to provide support that the injured worker has a condition that would require a compounded form when the medication is available in pill form. Established guidelines do not support use of Dicopanol. The request for Dicopanol is not medically necessary.

Unknown prescription of Fanatrex: 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 Not Addressed. Decision based on Non-MTUS Citation <http://www.drugs.com>.

Decision rationale: Fanatrex is a compounding kit for oral suspension of Gabapentin. Established guidelines show no evidence-based support for the use of oral suspension of Gabapentin and documentation fails to show that the injured worker has a condition that would require a compounded form when the medication is available in pill form. The request for Fanatrex is not medically necessary.

Unknown prescription of Synapryn: 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 Not Addressed. Decision based on Non-MTUS Citation <http://dailymed.nlm.nih.gov>.

Decision rationale: Synapryn is a compounding kit for oral suspension of Tramadol and Glucosamine. Established guidelines show no evidence-based support for the use of oral suspension or compounded form of these medications and documentation fails to show that the injured worker has a condition that would require an oral suspension of medications already available in pill form. The request for Synapryn is not medically necessary.

Unknown prescription of Tabradol: 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 Not Addressed. Decision based on Non-MTUS Citation <http://www.drugs.com>.

Decision rationale: Tabradol is a compounding kit for oral suspension of Cyclobenzaprine and Methylsulfonylmethane. Established guidelines show no evidence-based support for the use of oral suspension or compounded form of these medications and documentation fails to show that the injured worker has a condition that would require an oral suspension of medications already available in pill form. The request for Tabradol is not medically necessary.

Unknown prescription of Cyclobenzaprine: 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.

Decision rationale: MTUS states that the use of muscle relaxants as a topical agent is not recommended. Per guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request for Cyclobenzaprine 5% cream, 110gm is not medically necessary.

Unknown prescription of topical compound Ketoprofen cream: 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.

Decision rationale: Per MTUS, Ketoprofen is not recommended and is not currently FDA approved for a topical application. The request for topical compound Ketoprofen cream is therefore not medically necessary.