

Case Number:	CM15-0132750		
Date Assigned:	07/24/2015	Date of Injury:	06/20/2014
Decision Date:	09/17/2015	UR Denial Date:	06/10/2015
Priority:	Standard	Application Received:	07/09/2015

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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational 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 25 year old male, who sustained an industrial injury on 6/23/14. The injured worker was diagnosed as having lumbar spine sprain-strain and thoracic spine sprain-strain, lumbar disc displacement, sleep disorder and lumbar radiculopathy. Treatment to date has included chiropractic treatment, acupuncture, physical therapy, activity restrictions and oral medications. (MRI) magnetic resonance imaging of lumbar spine performed on 10/10/14 revealed L2-3 central focal disc herniation, L4-5 broad based disc herniation and Schmorl's node at L2. Currently on 4/29/15, the injured worker complains of burning, radicular mid back pain and muscle spasms, he rates the pain 6/10, he also complains of burning, radicular low back pain and muscle spasms and rates the pain 5/10; it is described as constant and severe. He also notes he awakens frequently during the night due to pain. He notes the medications provide temporary relief of pain and improve his ability to have restful sleep. He is to work full time without restrictions. Physical exam performed on 4/29/15 revealed tenderness to palpation at rhomboids and mid trapezium muscles, decreased thoracic range of motion, tenderness to palpation of lumbar paraspinal muscles and over the lumbosacral junction with restricted range of motion of lumbar spine and slightly decreased sensation of L4, 5 and S1 dermatomes bilaterally. The treatment plan included request for (MRI) magnetic resonance imaging of lumbar spine, (EMG) Electromyogram studies, continuation of oral medications including Deprezine, Dicopanlol, Fanatrex, Tabradol, Cyclobenzaprine, Ketoprofen cream, follow up appointment and shockwave therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 20% cream 165gm #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Online Version.

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

Decision rationale: Per the MTUS, topical analgesics are recommended as an option, they are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Ketoprofen is not currently FDA approved for a topical application, and has an extremely high incidence of photocontact dermatitis. A review of the injured workers medical records that are available to me do not reveal a failed trial of recommended first line agents, therefore the request for Ketoprofen is not medically necessary.

Cyclobenzaprine 5% cream 100gm #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Online Version.

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

Decision rationale: Cyclobenzaprine is not FDA approved for use as a topical application. There is no evidence for the use of any muscle relaxant as a topical agent. There is no peer-reviewed literature to support its use. Medical necessity for the requested topical analgesic cream has not been established. According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. There is no documentation to support failed trial of antidepressants and anticonvulsants. Therefore, the request for Cyclobenzaprine cream is not medically necessary.

Synapryn 10mg/ml 500ml #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Online Version, Opioids criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

Decision rationale: According to the California MTUS, Synapryn oral suspension (Tramadol hydrochloride) is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. According to the medical records, there has been no documentation of the medication's analgesic effectiveness or functional improvement, and no clear documentation that the patient has responded to ongoing opioid therapy. The injured worker has been prescribed Synapryn for at least 6 months and is currently working full time. An oral suspension is a suspension consisting of un-dissolved particles of one or more medicinal agents mixed with a liquid vehicle for oral administration. Evidence-based guidelines and peer-reviewed medical literature do not address the use of medications in oral suspension form. Oral suspensions of medications are generally for use in patients for whom taking the pill/tablet form of the medication is either impractical or unsafe. In this case, there is no documentation in the medical records of any conditions that would preclude the use of medications in their pill/tablet form. Medical necessity for the requested Synapryn 10mg/1 ml Oral Suspension has not been established. The requested medication is not medically necessary.

Tabradol 1mg/ml 250ml #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain), Antispasmodics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity drugs, Cyclobenzaprine Page(s): 63.

Decision rationale: According to the reviewed literature, Tabradol (Cyclobenzaprine) oral suspension is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. There is no documentation of functional improvement from any previous use of this medication. In this case, the injured worker has utilized Tabradol for at least 6 months. Tabradol oral suspension is a suspension consisting of un-dissolved particles of one or more medicinal agents mixed with a liquid vehicle for oral administration. Evidence-based guidelines and peer-reviewed medical literature do not address the use of medications in oral suspension form. Oral suspensions of medications are generally for use in patients for whom taking the pill/tablet form of the medication is either impractical or unsafe. In this case, there is no documentation in the medical records of any conditions that would preclude the use of medications in their pill/tablet form. Based on the currently available information, the medical necessity for Tabradol 1mg/ml Oral Suspension has not been established. The requested medication is not medically necessary.

Deprizine 15mg/ml 250ml #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms & cardiovascular risk.

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

Decision rationale: Deprizine (Ranitidine) oral suspension is a histamine blocker and antacid used to treat peptic ulcers, gastritis and gastro-esophageal reflux (GERD). Ranitidine works by blocking the effects of histamine on the receptor site known as H2. Proton Pump Inhibitors (PPI's) are prescribed to prevent and treat ulcers in the duodenum (where most ulcers develop) and the stomach. In this case, there is no documentation to indicate a peptic ulcer, gastritis or gastroesophageal reflux disease. Deprizine oral suspension is a suspension consisting of undissolved particles of one or more medicinal agents mixed with a liquid vehicle for oral administration. Evidence-based guidelines and peer-reviewed medical literature do not address the use of medications in oral suspension form. Oral suspensions of medications are generally for use in patients for whom taking the pill/tablet form of the medication is either impractical or unsafe. In this case, there is no documentation in the medical records of any conditions that would preclude the use of medications in their pill/tablet form. Medical necessity of the Deprizine (Ranitidine) oral suspension has not been established. The requested medication is not medically necessary.

Fanatrex 25mg/ml 420ml #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-convulsants (anti-epilepsy drugs) Gabapentin Page(s): 16-18.

Decision rationale: According to the CA MTUS (2009), Fanatrex oral suspension (Gabapentin) is an anti-epilepsy drug, which has been considered a first-line treatment for neuropathic pain. Oral suspensions of medications are generally for use in patients for whom taking the pill/tablet form of the medication is either impractical or unsafe. In this case, there is no documentation in the medical records of any conditions that would preclude the use of medications in their pill/tablet form. The injured worker has utilized the medication for at least 6 months. Medical necessity for the requested medication, Fanatrex 25mg/ml oral suspension, has not been established. The requested medication is not medically necessary.

Shockwave Therapy for Thoracic & Lumbar Spine 3 x 6: 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) Chapter, Online Version.

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

Decision rationale: The MTUS/ACOEM did not address the use of Shockwave therapy therefore other guidelines were consulted. Per the ODG, Shockwave therapy is "not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating LBP. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged". Therefore the request for shockwave therapy for lumbar and thoracic spine is not medically necessary.

MRI Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303 and 304.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

Decision rationale: CA MTUS guidelines recommend (MRI) magnetic resonance imaging studies for nerve impairment or tissue injury indicated by physiologic evidence. (MRI) magnetic resonance imaging of lumbar spine performed on 10/10/14 revealed the cause of the symptoms. In this case there has been no change in the symptoms presented by the injured worker since the previous (MRI) magnetic resonance imaging. The (MRI) magnetic resonance imaging is not medically necessary.

EMG/NCV bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303 and 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar & Thoracic (Acute & Chronic) Chapter, Online Version.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (EMG) Electromyogram testing, low back.

Decision rationale: CA MTUS guidelines recommend (EMG) Electromyogram studies to identify subtle, focal neurologic dysfunction when low back symptoms have lasted more than 3 or 4 weeks. ODG recommends (EMG) Electromyogram's to obtain unequivocal evidence of radiculopathy after 1 month of conservative therapy, but they are not necessary if radiculopathy is already clinically obvious. (MRI) magnetic resonance imaging of lumbar spine performed on 10/10/14 revealed the cause of the symptoms. As the guidelines state, if radiculopathy is already clinically obvious, the (MRI) magnetic resonance imaging is not medically necessary.