

Case Number:	CM15-0134208		
Date Assigned:	07/28/2015	Date of Injury:	05/05/2015
Decision Date:	09/21/2015	UR Denial Date:	07/07/2015
Priority:	Standard	Application Received:	07/10/2015

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 52 year old male, who sustained an industrial injury on 5/5/15. He reported injuries to his low back and knees after a fall. The injured worker was diagnosed as having low back pain, lumbar spine sprain-strain, rule radiculitis of lower extremity, bilateral knee sprain-strain and rule bilateral knees meniscal tear. Treatment to date has included shockwave therapy, physical therapy, oral medications. (MRI) magnetic resonance imaging of right knee performed on 6/8/15 revealed a vertical tear of the anterior horn of medial meniscus, linear increased intermediate signal in body of lateral meniscus, narrowed patella-femoral joint space with articular cartilage thinning and knee joint effusion. (MRI) magnetic resonance imaging of lumbar spine performed on 6/8/15 revealed degenerative anterolisthesis L3 on L4 and L4 on L5, disc desiccation at L1-2 to L5-S1, degenerative changes at inferior end plate of L1 to L5, straightening of the lumbar lordotic curvature, levoconvex scoliosis of lumbar spine, L1-2, L2-3, L3-4, L4-5 and L5-S1 diffuse disc herniation. (MRI) magnetic resonance imaging of right knee performed on 6/8/15 revealed linear increased signal in the body of the lateral meniscus, osteochondral defect at the posterior aspect of the lateral femoral condyle, patellar chondromalacia, knee joint effusion and cystic soft tissue lesion. Currently on 6/22/15, the injured worker complains of sharp, stabbing, low back pain and muscle spasms, he rates the pain 5-7/10, and describes it as constant, moderate to severe associated with numbness and tingling of the bilateral lower extremities. He also complains of burning bilateral knee pain and muscle spasms rated 5-7/10, described as constant moderate to severe with numbness, tingling and pain radiating to the feet. He notes the symptoms persist, but the medications offer temporary relief

of pain and improve sleep. Physical exam performed on 6/22/15 revealed pain with heel walking, squatting about 10% of normal due to back pain, bilateral lumbar paraspinal muscle guarding, tenderness to palpation at L2-5 spinous processes and restricted range of motion of lumbar spine; tenderness is noted to palpation over the medial and lateral joint line and to the patellofemoral joint bilaterally with restricted range of motion of bilateral knees. The treatment plan included Transcutaneous electrical nerve stimulation (TENS) unit with supplies, Hot-cold unit, continuation of physical therapy and shock wave therapy, acupuncture and chiropractic treatment, functional capacity evaluation, (EMG) Electromyogram-(NCV)Nerve Condition Velocity studies of bilateral lower extremities, localized intense neurostimulation therapy, pain management LSO brace and oral medications Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclobenzaprine and Ketoprofen cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics, Ketoprofen Page(s): 111-113, 54.

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 photo contact dermatitis. Medical necessity for the requested topical compounded medication has not been established. The requested topical analgesic compound is not medically necessary.

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 NSAIDS (non-steroidal anti-inflammatory drugs) gastrointestinal symptoms and cardiovascular risks Page(s): 68-69.

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. 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.

Dicopanol: 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, insomnia.

Decision rationale: The treating physician has stated that Dicopanol is diphenhydramine and other unnamed ingredients. Medical necessity cannot be determined for unspecified compounds, and unpublished ingredients cannot be assumed to be safe or effective. Dicopanol is not medically necessary on this basis alone. In addition, Dicopanol is stated to be for insomnia. The MTUS does not address the use of hypnotics other than benzodiazepines. No physician reports describe the specific criteria for a sleep disorder. Treatment of a sleep disorder, including prescribing hypnotics, should not be initiated without a careful diagnosis. There is no evidence of that in this case. Antihistamines are not indicated for long term use as tolerance develops quickly, and that there are many, significant side effects. Furthermore, dosage or administration information is not provided with the request. Dicopanol is not medically necessary based on lack of a sufficient analysis of the patient's condition, the ODG citation, and lack of information provided about the ingredients.

Extracorporeal shockwave therapy x 12 sessions: 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 & Leg.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) / Extracorporeal shock wave therapy (ESWT).

Decision rationale: The MTUS / ACOEM did not sufficiently address the use of shockwave treatments for lumbar spine therefore other guidelines were consulted. Per the ODG, ECSWT is not recommended for back pain. The available evidence does not support the effectiveness of shock wave for treating back pain. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. A review of the injured workers medical records that are available to me do not reveal extenuating circumstances that would warrant deviating from the guidelines therefore the request for 12 sessions Extracorporeal shockwave treatments is not medically necessary.

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 anti-epilepsy drugs Page(s): 16-17. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Gabapentin.

Decision rationale: According to the CA MTUS (2009) and ODG, 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. Furthermore, the request for Fanatrex did not include instructions for administration or dosage information. Medical necessity for the requested medication, Fanatrex, has not been established. The requested medication is not medically necessary.

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 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. An 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. The treatment request did not include directions for usage or any dosage information. Medical necessity for the requested Synapryn Oral Suspension has not been established. Of note, discontinuation of an opioid analgesic requires a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

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 Muscle relaxants 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. Tabradol 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. Furthermore, the request for treatment did not include dosage information or administration information. Based on the currently available information, the medical necessity for Tabradol Oral Suspension has not been established. The requested medication is not medically necessary.

Cyclobenzaprine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants, cyclobenzaprine Page(s): 41, 63.

Decision rationale: According to the reviewed literature, Cyclobenzaprine is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. Guidelines state that this medication is not recommended to be used for longer than 2-3 weeks. 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. The request for Cyclobenzaprine did not include dosage or administration information. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested medication is not medically necessary.

TENS unit with supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS.*CharFormat

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS (transcutaneous electrical nerve stimulation) Page(s): 114-116.

Decision rationale: TENS (transcutaneous electrical nerve stimulation) is electrical stimulation applied to the surface of the skin. It is not recommended as a primary treatment modality, but on occasion a one month home based trial may be considered as a conservative option with a functional restoration program. It is recommended for treatment of neuropathic and CRPSII pains, as a supplement to medical treatment for spasticity in spinal cord injury and multiple sclerosis spasticity. Criteria for use includes documentation of pain at least three months in duration, evidence of failed pain modalities, ongoing pain treatment should be documented and a treatment plan with specific goals of treatment should be submitted. In this case, the pain has not lasted for at least 3 months. The request for TENS unit is not medically necessary at this time.

Hot/cold unit: 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 & Leg.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and leg, continuous flow cryotherapy.

Decision rationale: The MTUS/ ACOEM did not specifically address the use of cryotherapy units, therefore other guidelines were consulted. Hot-cold unit is a form of continuous flow cryotherapy. ODG guidelines do not recommend continuous flow cryotherapy for non-surgical treatment. The medical necessity of the hot-cold unit is not determined, as the injured worker is not post-surgical.

Functional capacity evaluation: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for duty, functional capacity evaluation.

Decision rationale: The ODG recommends a functional Capacity evaluation (FCE) prior to admission of a work hardening program with assessments tailored to a specific job. It is not recommended for routine occupational rehab or screening. Guidelines for performing a FCE, prior unsuccessful return to work attempts, conflicting medical reporting on precautions or

fitness for modified job and injuries that require detailed exploration of an injured worker's abilities; the injured worker should be close or at MMI and additional conditions are clarified. In this case, the injured worker has not made attempts to return to work and it is not documented he is at MMI. The medical necessity of a FCE has not been determined. The request is not medically necessary.

Localized intense neurostimulation therapy x 9: 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) low back, hyperstimulation analgesia.

Decision rationale: Localized high intensity neurostimulation devices are not recommended by ODG until there are higher quality studies. High intensity neurostimulation devices are applied to small areas of the skin to stimulate peripheral nerve endings. There is lack of evidence of efficacy in supporting literature. The request for Localized intense neurostimulation therapy is not medically necessary due to lack of sufficient evidence.

Trigger point impedance imaging x 9 sessions 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) trigger point impedance, back.

Decision rationale: ODG guidelines do not recommend trigger point impedance imaging with hyper-stimulation analgesia. The guidelines oppose use. In this case, there is no documentation that would make this imaging medically necessary. The request for trigger point impedance imaging is not medically necessary.