

Case Number:	CM15-0134557		
Date Assigned:	07/22/2015	Date of Injury:	02/08/2012
Decision Date:	10/13/2015	UR Denial Date:	07/10/2015
Priority:	Standard	Application Received:	07/13/2015

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: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 51 year old male, who sustained an industrial injury on February 8, 2012. Treatment to date has included MRI of the right knee, hernia repair, and medications. Currently, the injured worker complains of right knee pain and rates his right knee pain a 4-5 on a 10-point scale. He describes his right knee pain as constant, mild-to-moderate pain and notes that the knee pain is aggravated with squatting, kneeling, navigating stairs and prolonged positioning. He is status post abdominal surgery for hernia repair and rates his abdominal pain a 4 on a 10-point scale. He describes the abdominal pain as constant and moderate-to-severe. He reports that medications offer temporary relief from the pain and improve his ability for a restful sleep. On physical examination the injured worker has tenderness to palpation at the right lower abdominal quadrant and at the right knee medial joint line. He is able to perform a heel and toe walk, however walking on his heels elicits pain. He is able to squat to approximately 20% of normal due to his pain and has a slight effusion of the right knee. His right knee range of motion is limited on flexion and he has a positive McMurray's test on the right. There is slight right lower extremity weakness noted with intact sensation and reflexes. The diagnoses associated with the request include status post abdominal surgery with residual pain, abdominal hernia, right knee internal derangement, right knee medial meniscal tear and right knee anterior cruciate ligament tear. The treatment plan includes acupuncture for the right knee, right knee shockwave therapy, Fanatrex, Terocin patches, Deprizine, Dicopanol, Synapryn, Tabradol, Cyclobenzaprine cream, Ketoprofen Cream and physical therapy for the right knee. Also of note, letter of medical necessity written 02.2015 by [REDACTED] was reviewed, explaining the rationale behind the various medication requests.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fanatrex 25mg/ml 420ml: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 13th Edition (web), 2015, Pain Chapter, Compound drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: California MTUS Guidelines state that Fanatrex, which contains Gabapentin and other proprietary ingredients, has been shown to be effective in treating diabetic neuropathy and post-herpetic neuralgia and can be considered a first line agent for treating neuropathic pain. After initiation of treatment there should be documentation of pain relief, and improvement of function, as well as documentation of side effects incurred with use. The continued use of AEDs depend upon improved outcomes versus tolerability and adverse effects. According to documentation submitted by [REDACTED], the injured worker has found it difficult to describe his chronic pains precisely, but yet, it is clear to [REDACTED] there are elements of neuropathic pain contributing. With this in mind, the request for Fanatrex can be considered reasonable and is medically necessary.

Right Knee Acupuncture 3 x 6: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: According to the MTUS guidelines, acupuncture can be considered when pain medications are not tolerated, or reduced. It may also be used as an adjunct to physical rehabilitation or surgical intervention to hasten functional recovery. Typical time frame needed to produce functional benefit is 3-6 sessions. While the injured worker complains of chronic right knee pain, and has evidence of internal derangement and ACL injury, the request as submitted exceeds guideline recommendations for an initial trial and thus, is not medically necessary at this time.

Right Knee Physical Therapy 3 x 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical therapy.

Decision rationale: According to the California MTUS, for various myalgias and neuralgias, physical therapy is indicated for up to 8-10 sessions. The ODG recommends six visit clinical trials to determine if the injured worker is making positive, negative, or no gains with treatment.

The request as submitted exceeds guideline recommendations for a six visit trial. At this time, this request is not medically necessary.

Right knee shockwave therapy x 3 treatments: 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) Treatment Index, 13th Edition (web), 2015, Knee & Leg Chapter, Extracorporeal shock wave therapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Leg chapter, Shockwave therapy (ESWT).

Decision rationale: According to the ODG, shockwave therapy is under study for patellar tendinopathy and for long-bone hypertrophic nonunions. The American College of Sports Medicine suggest ESWT is ineffective for patellar tendinopathy as compared to physical therapy, focusing on joint mobilization, muscle retraining, and patellar taping. The injured worker does not carry a diagnosis compatible with guidelines as it pertains to ESWT and thus, this request is not medically necessary.

Terocin Patches: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Per MTUS guidelines, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anti-convulsants and/or anti-depressants have failed. The guidelines go on to state that when any compounded product contains 1 medication that is not recommended, the compounded product as a whole is not recommended. Terocin contains Lidocaine and menthol. Lidocaine is approved for topical use in patch form and indicated for post-herpetic neuralgia and this injured worker does not carry this diagnosis and thus is not compatible with guideline use of Terocin patch. Therefore, this request is not medically necessary.

Deprizine 15mg/ml #250ml: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 13th edition (web), 2015, Pain Chapter, Compound drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: According to the California MTUS, those at high risk of developing gastrointestinal events would benefit from proton pump inhibitor gastric prophylaxis. The MTUS does not specifically address Deprizine, but this agent contains Ranitidine (an H2

blocker) and other proprietary ingredients. [REDACTED] notes that this injured worker has dyspepsia as he has had chronic pain and used non-steroidal anti-inflammatory drugs that caused his gastrointestinal events. As such, the use of Deprizine is considered medically reasonable and is medically necessary.

Dicopanol 5mg/ml 150ml: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 13th edition (web), 2015, Pain Chapter, Compound drugs.

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

Decision rationale: ODG notes that sedating anti-histamines have been suggested for sleep aids. Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. The FDA indications for diphenhydramine include use as an antihistaminic, in the management of motion sickness, and parkinsonism, and as a nighttime sleep aid. Within the submitted documentation, [REDACTED] notes that this injured worker has not had tolerance to Dicopanol, which contains Diphenhydramine and other proprietary ingredients, and has much more restorative sleep with the use of this agent. He refers to other sleep aids as posing greater risks for adverse events, including Ambien. With this in mind, considering the moderate insomnia this injured worker deals with, improved with Dicopanol, this request is reasonable and medically necessary.

Synapryn 10mg/1ml #500ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 13th edition (web), 2015, Pain Chapter, Compound drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for neuropathic pain.

Decision rationale: Synapryn contains Tramadol and Glucosamine, as well as other proprietary ingredients. The CA MTUS Chronic Pain Medical Treatment Guidelines state that Tramadol is not recommended as a first line oral analgesic. Ongoing use of opiates requires documentation of the 4 A's including analgesia, activities of daily living, aberrant behavior, and adverse events. Within the documentation, the specific objective, functional, and pain score response to Synapryn was not documented. Medical necessity for ongoing use has not yet been substantiated. The request is not medically necessary.

Tabradol 1mg/ml #250ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 13th edition (web), 2015, Pain Chapter, Compound drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril).

Decision rationale: Tabradol contains Cyclobenzaprine, methylsulfonylmethane and other proprietary ingredients. The MTUS states that Cyclobenzaprine treatment should be brief, with a short course of therapy. Additionally, the MTUS states that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Within the submitted documentation, there is no mention objective, functional, or pain score improvements noted with the use of Tabradol. There are no extenuating factors to warrant non-adherence to guideline criteria. Medical necessity has not been substantiated at present time. The request is not medically necessary.

Cyclobenzaprine 5% cream 110 grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Per MTUS guidelines, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anti-convulsants and/or anti-depressants have failed. The guidelines go on to state that when any compounded product contains 1 medication that is not recommended, the compounded product as a whole is not recommended. Cyclobenzaprine is not recommended for topical use. Furthermore, there are requests for topical and oral formulations of Cyclobenzaprine, without a clear rationale as to why both are necessary. Medical necessity has not been established. The request is not medically necessary.

Ketoprofen Cream 20% cream 167 grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Per MTUS guidelines, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anti-convulsants and/or anti-depressants have failed. The guidelines go on to state that when any compounded product contains 1 medication that is not recommended, the compounded product as a whole is not recommended. Ketoprofen is not FDA approved for topical application as it carries a high risk of photo contact dermatitis. The only FDA approved topical NSAID is Diclofenac. With this in mind, this request is not supported and is not medically necessary.