

Case Number:	CM15-0136432		
Date Assigned:	07/30/2015	Date of Injury:	10/01/2003
Decision Date:	10/09/2015	UR Denial Date:	07/01/2015
Priority:	Standard	Application Received:	07/14/2015

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

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:

This is a 57 year old female with an October 1, 2003 date of injury. A progress note dated May 28, 2015 documents subjective complaints (status post cervical spine fusion with residual pain; pain rated at a level of 6 out of 10; associated numbness and tingling of the bilateral upper extremities; burning right knee pain and muscle spasms; pain rated at a level of 6 out of 10; difficulty sleeping), objective findings (tenderness at the lateral aspect of the occiput, the trapezius, splenius, scalene muscles, and over the levator scapula muscles with trigger points noted bilaterally; tenderness to palpation of the rhomboid muscles with a burning sensation; decreased range of motion of the cervical spine; positive Spurling's, cervical distraction, and cervical compression tests; sensation to pinprick and light touch is diminished over C5, C6, and C7 dermatomes in the bilateral upper extremities; 1+ effusion noted at the right knee; pain in the right knee with heel walking; crepitus is noted with motion; tenderness to palpation over the medial and lateral joint line and to the patellofemoral joint; decreased range of motion of the right knee; motor strength is slightly decreased in the right lower extremity secondary to pain), and current diagnoses (status post cervical spine fusion with residual pain; cervical radiculopathy; unspecified internal derangement of the right knee; sleep disorder). Treatments to date have included cervical spine fusion, medications, imaging studies, physical therapy, and psychotherapy. The medical record indicates that medications help control the pain. The treating physician documented a plan of care that included a urine drug screen, Ketoprofen cream, Cyclobenzaprine cream, Synapryn oral suspension, Tabradol oral suspension, Deprizine oral suspension, physical therapy, physiotherapy, acupuncture, chiropractic treatments, Dicopanol oral suspension, and Fanatrex oral suspension.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective: Urine drug screen (DOS: 5/28/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic): Urine drug testing (UDT).

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

Decision rationale: The MTUS recommends using a urine drug screen to assess for the use or the presence of illegal drugs, a step to take before a therapeutic trial of opioids, to aid in the ongoing management of opioids, or to detect dependence and addiction. There is no documentation in the medical record that a urine drug screen was to be used for any of the above indications. Urine drug screen is not medically necessary.

Retrospective: Ketoprofen 20% cream 165gm (DOS: 5/28/15): 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: According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Ketoprofen agent is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. Retrospective: Ketoprofen 20% cream 165gm (DOS: 5/28/15) is not medically necessary.

Retrospective: Cyclobenzaprine 5% cream 110gm (DOS: 5/28/15): 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: According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. 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 muscle relaxant as a topical product. Retrospective: Cyclobenzaprine 5% cream 110gm (DOS: 5/28/15) is not medically necessary.

Retrospective: Synapryn 10mg/1ml oral suspension 500ml (DOS: 5/28/15): 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 (Chronic), Compound drugs.

Decision rationale: The requested compound medication contains unnamed and then defined "other proprietary ingredients." In addition, there is no documentation that the patient has a contraindication to medication prescribed in tablet form. According to the Official Disability Guidelines, compounded drugs are not recommended as a first-line therapy. In general, commercially available, FDA-approved drugs should be given an adequate trial. If these are found to be ineffective or are contraindicated in individual patients, compound drugs that use FDA-approved ingredients may be considered. There is no documentation that the FDA approved medication was given an adequate trial. Retrospective: Synapryn 10mg/1ml oral suspension 500ml (DOS: 5/28/15) is not medically necessary.

Retrospective: Tabradol 1mg/ml oral suspension 250ml (DOS: 5/28/15): 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 (Chronic), Compound drugs.

Decision rationale: The requested compound medication contains unnamed and then defined "other proprietary ingredients". In addition, there is no documentation that the patient has a contraindication to medication prescribed in tablet form. According to the Official Disability Guidelines, compounded drugs are not recommended as a first-line therapy. In general, commercially available, FDA-approved drugs should be given an adequate trial. If these are found to be ineffective or are contraindicated in individual patients, compound drugs that use FDA-approved ingredients may be considered. There is no documentation that the FDA approved medication was given an adequate trial. Retrospective: Tabradol 1mg/ml oral suspension 250ml (DOS: 5/28/15) is not medically necessary.

Retrospective: Deprizine 15mg/ml oral suspension 250ml (DOS: 5/28/15): 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 (Chronic), Compound drugs.

Decision rationale: The requested compound medication contains unnamed and then defined "other proprietary ingredients". In addition, there is no documentation that the patient has a contraindication to medication prescribed in tablet form. According to the Official Disability Guidelines, compounded drugs are not recommended as a first-line

therapy. In general, commercially available, FDA-approved drugs should be given an adequate trial. If these are found to be ineffective or are contraindicated in individual patients, compound drugs that use FDA-approved ingredients may be considered. There is no documentation that the FDA approved medication was given an adequate trial.

Retrospective: Deprizine 15mg/ml oral suspension 250ml (DOS: 5/28/15) is not medically necessary.

Retrospective: 18 sessions of physical therapy (DOS: 5/28/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation ODG Physical Therapy Guidelines; Neck & Upper Back (Acute & Chronic): Physical therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: The MTUS allows for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Prior to full authorization, therapeutic physical therapy is authorized for trial of 6 visits over 2 weeks, with evidence of objective functional improvement prior to authorizing more treatments. There is no documentation of objective functional improvement and the request is for greater than the number of visits necessary for a trial to show evidence of objective functional improvement prior to authorizing more treatments. Retrospective: 18 sessions of physical therapy (DOS: 5/28/15) is not medically necessary.

Retrospective: 18 sessions of physiotherapy (DOS: 5/28/15): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Physical Medicine Guidelines; Knee & Leg (Acute & Chronic): Physical medicine treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: The MTUS allows for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Prior to full authorization, therapeutic physical therapy is authorized for trial of 6 visits over 2 weeks, with evidence of objective functional improvement prior to authorizing more treatments. There is no documentation of objective functional improvement and the request is for greater than the number of visits necessary for a trial to show evidence of objective functional improvement prior to authorizing more treatments. Retrospective: 18 sessions of physiotherapy (DOS: 5/28/15) is not medically necessary.

Retrospective: 18 sessions of acupuncture (DOS: 5/28/15): Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: The Acupuncture Medical Treatment Guidelines state that the initial authorization for acupuncture is for 3-6 treatments. Authorization for more than 6 treatments

would be predicated upon documentation of functional improvement. The request for 18 treatments is greater than the number recommended for a trial to determine efficacy. Retrospective: 18 sessions of acupuncture (DOS: 5/28/15) is not medically necessary.

Retrospective: 18 sessions of chiropractic treatment (DOS: 5/28/15): Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, and Knee Complaints 2004, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation ODG Chiropractic Guidelines, Regional neck pain; Knee and Leg- Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: The request is for 18 visits of chiropractic. The Chronic Pain Medical Treatment Guidelines allow for an initial 4-6 visits after which time there should be documented functional improvement prior to authorizing more visits. The request for 18 chiropractic visits is more than what is medically necessary to establish whether the treatment is effective. Retrospective: 18 sessions of chiropractic treatment (DOS: 5/28/15) is not medically necessary.

Retrospective: Dicopanol (Diphenhydramine) 5mg/ml oral suspension 150ml (DOS: 5/28/15): 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 (Chronic), Compound drugs.

Decision rationale: The requested compound medication contains unnamed and then defined "other proprietary ingredients". In addition, there is no documentation that the patient has a contraindication to medication prescribed in tablet form. According to the Official Disability Guidelines, compounded drugs are not recommended as a first-line therapy. In general, commercially available, FDA-approved drugs should be given an adequate trial. If these are found to be ineffective or are contraindicated in individual patients, compound drugs that use FDA-approved ingredients may be considered. There is no documentation that the FDA approved medication was given an adequate trial. Retrospective: Dicopanol (Diphenhydramine) 5mg/ml oral suspension 150ml (DOS: 5/28/15) is not medically necessary.

Retrospective: Fanatrex (Gabapentin) 25mg/ml oral suspension 420ml (DOS: 5/28/15): 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 (Chronic), Compound drugs.

Decision rationale: The requested compound medication contains unnamed and then defined "other proprietary ingredients". In addition, there is no documentation that the patient has a contraindication to medication prescribed in tablet form. According to the Official Disability Guidelines, compounded drugs are not recommended as a first-line therapy. In general, commercially available, FDA-approved drugs should be given an adequate trial. If these are found to be ineffective or are contraindicated in individual patients, compound drugs that use FDA-approved ingredients may be considered. There is no documentation that the FDA approved medication was given an adequate trial. Fanatrex (Gabapentin) 25mg/ml oral suspension 420ml (DOS: 5/28/15) is not medically necessary.