

Case Number:	CM15-0164090		
Date Assigned:	09/10/2015	Date of Injury:	05/12/2006
Decision Date:	10/27/2015	UR Denial Date:	07/28/2015
Priority:	Standard	Application Received:	08/21/2015

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: Physical Medicine & Rehabilitation, Pain Management

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 64-year-old female worker who was injured on 05-12-2006. The medical records reviewed indicated the injured worker (IW) was treated for cervical and lumbar spine herniated nucleus pulposus; cervical radiculopathy; bilateral shoulder internal derangement; right shoulder tenosynovitis; bilateral wrist internal derangement; osteoarthritis, localized, primary, bilateral hands; lumbar spine degenerative disc disease; lumbar radiculopathy; total right knee replacement; and sleep disorder. The progress notes dated 7-28-2015 indicated the IW had burning, radicular neck pain associated with numbness and tingling in the bilateral upper extremities; burning, radicular shoulder pain radiating down the arms to the fingers, with associated muscle spasms; burning, bilateral wrist pain and muscle spasms; burning, radicular low back pain and muscle spasms with associated numbness and tingling in the bilateral lower extremities; and burning bilateral knee pain and muscle spasms. According to the progress notes from April 2015 through July 2015, her pain improved slightly from 7 to 8 out of 10 to 5 to 6 and 6 to 7 out of 10. The IW also complained of difficulty sleeping due to the uncertainty about the future of her career. She reported being anxious and depressed about being unable to work and perform her normal activities of daily living. She reported the medications relieved her pain temporarily and improved her ability to sleep. On examination, there was 2+ tenderness to palpation at the suboccipital region as well as over the scalene and trapezius muscles. Range of motion (ROM) was decreased in the cervical spine, bilateral shoulders and wrists and in the lumbar spine. There was tenderness and spasms in the lumbar spine and straight leg raise was positive bilaterally at 40 degrees. There was crepitus with motion of the bilateral knees. ROM of

the right knee was 125 degrees flexion and -10 degrees extension. McMurray's test was positive bilaterally. Sensation was decreased to pinprick and light touch at the L4, L5 and S1 dermatomes bilaterally. Motor strength was decreased in the bilateral lower extremities due to pain. Reflexes and pulses in the lower extremities were normal. Treatments documented included medications (Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclobenzaprine (topical) and Ketoprofen cream); right knee arthroscopy and total knee replacement; physical therapy; and trigger point injections. The right knee remained symptomatic. According to the records reviewed, Deprizine, Dicopanol, Fanatrex, Synapryn and Tabradol were prescribed since at least 11-15-2014 and Ketoprofen and Cyclobenzaprine cream since at least 11-25-2014. Electrodiagnostic testing was done 5-11-2012, showing evidence consistent with right knee and right ankle peroneal nerve peripheral neuropathy. An MRI of the lumbar spine on 9-21-2014 showed multilevel disc herniation and facet hypertrophy, causing stenosis of the spinal canal, bilateral lateral recesses and the bilateral neural foramen with contact on the bilateral L3, L4 and L5 transiting nerve roots and on the bilateral L3, L4 and L5 exiting nerve roots. An updated lumbar MRI on 5-3-2015 was similar, but also noted deviation of the S1 transiting nerve roots. An MRI of the right knee was done on 9-28-2014; there was artifact due to the metal implant, but there was no abnormal marrow signal to suggest fracture or lesion, the visualized musculature appeared within normal limits and there was no mass or fluid visualized. A Request for Authorization dated 7-28-2015 asked for an MRI of the right knee; one EMG-NCV (electromyography-nerve conduction velocity) of the lower extremities; Deprizine, unknown; Dicopanol, unknown; Fanatrex, unknown; Synapryn, unknown; Tabradol, unknown; Cyclobenzaprine, unknown; Ketoprofen cream, unknown; and one retrospective urine drug screen. The Utilization Review on 7-28-2015 denied the request for an MRI of the right knee because the IW had a conclusive, diagnostic bone scan on 6-20-2014. EMG-NCV testing was denied because the IW had no history of radiculopathy and no indication of symptom changes since the previous testing. Deprizine, Dicopanol and Fanatrex were denied because there were no clinical findings indicating a need for oral suspension medications and no evidence of previous positive response. Synapryn was denied due to lack of documentation that recent alternative medications had been attempted and failed and because there were no clinical findings indicating a need for oral suspension medications. Tabradol was denied because it is also known as Cyclobenzaprine, for which there was a concurrent request; it was considered a duplicate request. Cyclobenzaprine (topical gel) was denied because the guidelines do not support any muscle relaxant as a topical product. Ketoprofen cream was denied because the guidelines do not recommend this topical agent and it is not currently FDA approved for topical application. The request for a retrospective urine drug screen was denied because the concurrent request for opioid drugs was not medically appropriate.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, MRI Topic.

Decision rationale: Regarding the request for repeat MRI of the knee, ACOEM guidelines do not have specifics on repeat imaging. The Official Disability Guidelines do note that repeat imaging should be reserved for a significant change in pathology. The injured worker has documentation of a prior MRI of the right knee completed on 9/28/2014 with findings of artifact due to the metal implant, no abnormal marrow signal to suggest fracture or lesion, musculature appeared within normal limits, and there was no mass or fluid visualized. Although chronic knee pain is documented both subjectively and objectively, it is unclear as to what constitutes a change since the date of the last MRI imaging. In light of the above, the currently requested repeat right knee MRI is not medically necessary.

EMG/NCV of the lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Electrodiagnostic Studies.

Decision rationale: Regarding the request for EMG and nerve conduction study of the lower extremities, ACOEM Chapter 12 states that unequivocal objective findings that identify specific nerve compromise on the neurologic exam are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery. When a neurologic examination is less clear however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. They go on to state that electromyography may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. Within the documentation available for review, there are documentation of burning, radicular low back pain and muscle spasms with associated numbness and tingling in the bilateral lower extremities, Physical exam revealed decreased sensation to pinprick and light touch at the L4, L5 and S1 dermatomes bilaterally, and decreased motor strength in the bilateral lower extremities due to pain. A prior electrodiagnostic testing completed on 5/11/2012 showed evidence consistent with right knee and right ankle peroneal nerve peripheral neuropathy. Regarding this request, it is unclear how current symptoms have changed since prior electrodiagnostic study to warrant the repeat study at this time. Furthermore, the provider did not indicate how the findings on EMG and NCS would change the management. As such, this request is not medically necessary.

Deprizine, unknown: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation <http://www.drugs.com/pro/deprizine.html>.

Decision rationale: Regarding the request for Deprizine, Deprizine contains active and inactive bulk materials to compound a ranitidine hydrochloride oral suspension. California MTUS states that H2 antagonists such as ranitidine are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this oral suspension medication. In light of the above issues, the currently requested Deprizine is not medically necessary.

Dicopanol, unknown: 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 Chapter, Insomnia treatment.

Decision rationale: Regarding the request for Dicopanol, Dicopanol contains active and inactive bulk materials to compound a diphenhydramine hydrochloride oral suspension. California MTUS guidelines are silent regarding this medication. ODG states sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine). Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there are no discussion regarding how frequently the insomnia complaints occur or how long they have been occurring, no statement indicating what behavioral treatments have been attempted for the condition of insomnia, and no statement indicating how the patient has responded to treatment with Dicopanol. Finally, there is no indication of why an oral suspension formulation is necessary, as opposed to a tablet form of this drug which is available as a generic. Given this, the currently requested Dicopanol is not medically necessary.

Fanatrex, unknown: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Anti-epilepsy drugs (AEDs). Decision based on Non-MTUS Citation <http://www.drugs.com/pro/fanatrex.html>.

Decision rationale: Regarding the requested for Fanatrex, Fanatrex contains active and inactive bulk materials to prepare 420 mL of a gabapentin oral suspension containing 25 mg/mL gabapentin. Gabapentin is an anti-epileptic drug that is commonly used to treat neuropathic pain. The Chronic Pain Medical Treatment Guidelines state that anti-epilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is no identification of any specific analgesic benefit, and no documentation of specific objective functional improvement. Additionally, there is no discussion as to why an oral suspension as opposed to a tablet form that is available as a generic is necessary in this case. Given this, the currently requested Fanatrex is not medically necessary.

Synapryn, unknown: 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): Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: Regarding the request for Synapryn, this compound is noted to contain tramadol and glucosamine. With regard to opioids such as tramadol, California MTUS Chronic Pain Medical Treatment Guidelines state that, due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. With regard to glucosamine, it is recommended as an option in patients with moderate arthritis pain, especially for knee osteoarthritis. Within the documentation available for review, there is no indication that the medication is improving the patient's pain (in terms of percent reduction in pain or reduced NRS), no discussion regarding aberrant use, and no clear rationale for the use of this oral suspension compounded kit rather than the FDA-approved oral tablet forms. In the absence of such documentation, the currently requested Synapryn is not medically necessary.

Tabradol, unknown: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain). Decision based on Non-MTUS Citation <http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=5d19ef8b-eef3-4d52-95f5-929765ca6dc7>.

Decision rationale: Regarding the request for Tabradol, Tabradol contains cyclobenzaprine hydrochloride 1 mg/mL, in oral suspension with MSM - compounding kit. Regarding cyclobenzaprine, Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that cyclobenzaprine specifically is recommended for a short course of therapy. Within the documentation available for review, there is no identification of any objective functional improvement as a result of the cyclobenzaprine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested Tabradol is not medically necessary.

Cyclobenzaprine, unknown: 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: Regarding the request for topical cyclobenzaprine, Chronic Pain Medical Treatment Guidelines state that topical muscle relaxants are not recommended. They go on to state that there is no evidence for the use of any muscle relaxants as a topical product. Therefore, in the absence of guideline support for topical muscle relaxants, the currently requested cyclobenzaprine powder is not medically necessary.

Ketoprofen cream, unknown: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Regarding the request for this topical NSAID, the Chronic Pain Medical Treatment Guidelines state that topical NSAIDs are recommended for short-term use of 4-12 week duration for body regions that are amenable to topical treatment. Specifically, the CPMTG state: "There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder." A review of the submitted medical records indicates that the patient has long term use of Ketoprofen at least since 11/2014 which is not recommended by the guidelines. Given this, this request is not medically necessary.

Urine drug screen: 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): Opioids, criteria for use. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Urine Drug Testing.

Decision rationale: Regarding the request for a urine toxicology test, CA MTUS Chronic Pain Medical Treatment Guidelines state the drug testing is recommended as an option in patients on controlled substances. Guidelines go on to recommend monitoring for the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. ODG recommends urine drug testing on a yearly basis for low risk patients, 2-3 times a year for moderate risk patients, and possibly once per month for high risk patients. There risk stratification is an important component in assessing the necessity and frequency of urine drug testing. With the documentation available for review, there is no documentation of prescription of controlled substances. There is no risk factor assessment, such as the utilization of the Opioid Risk Tool or SOAPP is apparent in the records, which would dictate the schedule of random periodic drug testing. Given this, this request is not medically necessary.