MAXIMUS Federal Services

Case Number:	CM15-0204412		
Date Assigned:	10/21/2015	Date of Injury:	02/27/2013
Decision Date:	12/29/2015	UR Denial Date:	09/22/2015
Priority:	Standard	Application Received:	10/19/2015

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: Oregon
Certification(s)/Specialty: Plastic Surgery, Hand Surgery

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 injured worker is a 50 year old male, who sustained an industrial injury on 02-27-2013. The injured worker was diagnosed as having lumbar disc protrusion, lumbar sprain-strain and left shoulder sprain -strain. On medical records dated 08-20-2015 and 09-22-2015, the subjective complaints were noted as lower back pain and left shoulder pain. Pain was rated at 7 out of 10. Objective findings were noted as left shoulder tenderness to palpation at the supraspinus, trapezius, levator scapula and rhomboid muscles with a decreased range of motion was noted. Lumbar spine revealed tenderness to palpation in the lumbar paraspinal muscles and over the lumbarsacral junction with a decreased range of motion as well. Treatments to date included oral medication and topical creams. The injured worker was noted to be not working. Current medications were not specifically listed on 09-22-2015. The Utilization Review (UR) was dated 09-22-2015. A Request for Authorization was submitted. The UR submitted for this medical review indicated that the request for shockwave therapy visits, Cyclobenzaprine 5% cream, 110 gm, Deprizine 15mg-ml oral suspension 250ml, Dicopanol 5mg-ml oral suspension 150ml, Fanatrex 25mg-ml oral suspension 420 ml, Synapryn 10mg-ml oral suspension 420ml, Ketoprofen 20% cream 167 gm and Tabradol 1 mg-ml oral suspension 420ml was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription for Ketoprofen 20% Cream, 167 gm: Upheld

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

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

Decision rationale: Per MTUS page 111, Non-steroidal anti-inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. The patient has used topical NSAIDS in the past. MTUS does not support prolonged use of this medication as the efficacy persists for two weeks or less. The request is not medically necessary.

1 prescription for Cyclobenzaprine 5% Cream, 110 gm: Upheld

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

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

Decision rationale: Per MTUS page 113: Gabapentin: Not recommended. There is no peer-reviewed literature to support use. MTUS does not support topical gabapentin. The request is not medically necessary because MTUS does not support this treatment.

1 prescription for Synapryn 10/mg/1ml oral suspension, 500ml: 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): Opioids, specific drug list.

Decision rationale: Tramadol (Ultram) is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic Synapryn is an tramadol compounded medication. MTUS does not support Tramadol. In addition, ACOEM supports only short term use of opiates. The guidelines are exceeded. The request is not medically necessary.

1 prescription for Tabradol 1mg/ml oral suspension, 250ml: 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 rationale: Per MTUS page 84: Cyclobenzaprine (Flexeril, Amrix, Fexmid TM, generic available): Recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. Tabradol is cyclobenzaprine. MTUS only recommends short course use only. The patient has been on this medication for an extended period of time. The request exceeds guidelines and is not medically necessary.

1 prescription for Deprizine 15 mg/ml oral suspension 250ml: 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, GI symptoms & cardiovascular risk.

Decision rationale: MTUS (NSAIDs, GI symptoms & cardiovascular risk page 68) regarding the use of proton pump inhibitors (PPI) such as protonix, for prophylaxis use indicates that the following risk factors should be present, "(1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)." Documentation provided does not suggest that the patient has any of the noted risk factors noted above and the PPI is recommended non-certified. The patient does not have a history of anti-coagulation, previous reaction to NSAIDS or peptic ulcer disease. The patient is not older than 65, is not on steroids and is not on multiple or high dose NSAIDS. The guidelines do not support routine use of PPIs for patients taking NSAIDS. The request is not medically necessary.

1 prescription for Dicopanol (Diphenhydramine) 5mg/ml oral suspension, 150ml: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness & Stress: Diphenhydramine (Benadryl) (2015).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Physicians Desk Reference 2015.

Decision rationale: Diphenhydramine is a first-generation antihistamine possessing anticholinergic, antitussive, antiemetic, and sedative properties that is mainly used to treat allergies. It is also used in the management of drug-induced parkinsonism and other extra pyramidal symptoms. The records do not document problems with allergies, cough, vomiting or parkinsonism. The request is not medically necessary because the indication for this medication is not well defined in the records.

1 prescription for Fanatrex (Gabapentin) 25mg/ml oral suspension, 420ml: Overturned

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): Antiepilepsy drugs (AEDs).

Decision rationale: Per MTUS page 16: Anti-epilepsy drugs (AEDs) are also referred to as anti-convulsants: Recommended for neuropathic pain (pain due to nerve damage). Per MTUS page 18: Gabapentin (Neurontin, Gabarone TM, generic available) has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. MTUS supports treatment with gabapentin. The patient has chronic neuropathic pain. This drug is medically necessary as a first line treatment for the patient's pain.

18 Shockwave Therapy Visits: Upheld

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

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

Decision rationale: Per ODG: Extracorporeal shock wave therapy (ESWT)Recommended for calcifying tendinitis but not for other shoulder disorders. The records do not confirm that the patient has a diagnosis of calcifying tendinitis. ACOEM shoulder also only supports shock wave therapy for calcifying tendonitis. The request is not medically necessary because efficacy is unproven.