MAXIMUS Federal Services

Case Number:	CM15-0028865		
Date Assigned:	02/20/2015	Date of Injury:	09/15/2010
Decision Date:	04/16/2015	UR Denial Date:	01/29/2015
Priority:	Standard	Application Received:	02/17/2015

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: Texas, Florida, 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:

The injured worker is a 30-year-old female, who sustained an industrial injury on 09/15/2010. The diagnoses have included right shoulder sprain/strain, right carpal tunnel syndrome, right deQuervain's disease, right wrist sprain/strain, and status post right carpal tunnel release. Noted treatments to date have included chiropractic treatment, physiotherapy, acupuncture, wrist brace, Transcutaneous Electrical Nerve Stimulation Unit, and medications. No MRI report noted in received medical records. In a progress note dated 01/05/2015, the injured worker presented with complaints of sharp right shoulder pain radiating down the arm to the fingers, associated with muscle spasms. The treating physician reported that the injured worker's symptoms persist, but the medications do offer temporary relief of pain and improve her ability to have a restful sleep. Utilization Review determination on 01/28/2015 non-certified the request for Synapryn 10mg/1ml oral suspension 500ml, Tabradol 1mg/ml oral suspension 250ml, Deprizine 15mg/ml oral suspension 250ml, Dicopanol (diphenhydramine) 5mg/ml oral suspension 150ml, Fanatrex (gabapentin) 25mg/ml oral suspension 420ml, 1 Periodic Urinalysis Toxicological Evaluation, 18 Chiropractic treatments for Right Shoulder and Wrist, Terocin Patches, and 18 Physiotherapy Visits for the Right Shoulder and Wrist citing Medical Treatment Utilization Schedule, American College of Occupational and Environmental Medicine, Chronic Pain Medical Treatment Guidelines, Official Disability Guidelines, and National Guidelines Clearinghouse.

IMR ISSUES, DECISIONS AND RATIONALES

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

Synapryn 10mg/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 Treatment Guidelines Page(s): 12,13, 83 and 113.

Decision rationale: Synapryn is tramadol hydrochloride 10 mg/mL, in oral suspension with glucosamine - compounding kit).The most pharmacologically active component is the Tramadol Per the MTUS, Tramadol is an opiate analogue medication, not recommended as a first-line therapy. The MTUS based on Cochrane studies found very small pain improvements, and adverse events caused participants to discontinue the medicine. Most important, there are no long-term studies to allow it to be recommended for use past six months. Moreover, for all of the oral suspensions being reviewed in this case, it is not clear why oral formulations over simple pills are essential. A long term use of is therefore not supported.

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 Treatment Guidelines Page(s): 41-42.

Decision rationale: Tabradol is a formulation of cyclobenzaprine. The MTUS recommends cyclobenzaprine for a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. The addition of cyclobenzaprine to other agents is not recommended. In this case, there has been no objective functional improvement noted in the long-term use of Flexeril in this claimant. Long-term use is not supported. Also, it is being used with other agents, which also is not clinically supported in the MTUS.

1 Deprizine 15mg/ml oral suspension 250ml: 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, under Antidepressants.

Decision rationale: Deprazine is an antidepressant. The MTUS is silent on this specific oral syspension. medicine. Regarding antidepressants to treat a major depressive disorder, the ODG

notes: Recommended for initial treatment of presentations of Major Depressive Disorder (MDD) that are moderate, severe, or psychotic, unless electroconvulsive therapy is part of the treatment plan. Not recommended for mild symptoms. In this case, it is not clear what objective benefit has been achieved out of the antidepressant usage, how the activities of daily living have improved, and what other benefits have been. It is not clear if this claimant has a major depressive disorder. The request is appropriately non-certified.

Dicopanol (diphenhydramine) 5mg/ml oral suspension 150ml: 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 Physician Desk References, 2014 web edition, Dicopanol.

Decision rationale: Dicopanol is a suspension including diphenhydramine. Per the Physician Desk Reference, this is a medicine used for allergy. The records do not portray the patient as having an allergic condition. The use of the medicine to aid the injury care is not clinically clear based on the records. The request is appropriately not clinically certified.

Fanatrex (gabapentin) 25mg/ml oral suspension 420ml: 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 Page(s): 16, 19.

Decision rationale: Fanatrex is an oral suspension of gabapentin. The MTUS notes that anti-epilepsy drugs (AEDs) like Gabapentin are also referred to as anti-convulsants, and are recommended for neuropathic pain (pain due to nerve damage. However, there is a lack of expert consensus on the treatment of neuropathic pain in general due to heterogeneous etiologies, symptoms, physical signs and mechanisms. It is not clear in this case what the neuropathic pain generator is, and why therefore that Gabapentin is essential. Gabapentin (Neurontin, Gabarone, generic available) has been shown to be effective for treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. This claimant however has neither of those conditions. The request is appropriately non-certified under the MTUS evidence-based criteria.

1 periodic UA toxicological 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 (ODG), Urine Drug Testing (UDT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43.

Decision rationale: Regarding urine drug testing, the MTUS notes in the Chronic Pain section: Recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. For more information, see Opioids, criteria for use: (2) Steps to Take Before a Therapeutic Trial of Opioids & (4) On-Going Management; Opioids, differentiation: dependence & addiction; Opioids, screening for risk of addiction (tests); & Opioids, steps to avoid misuse/addiction. There is no mention of suspicion of drug abuse, inappropriate compliance, poor compliance, drug diversion or the like. There is no mention of possible adulteration attempts. The patient appears to be taking the medicine as directed, with no indication otherwise. It is not clear what drove the need for this drug test. The request is appropriately non-certified under MTUS criteria.

Terocin patches: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine, Topical; Capsaicin, Topical; Salicylate Topical.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111. Decision based on Non-MTUS Citation Physician Desk Reference, Terocin.

Decision rationale: Per the PDR, Terocin is a topical agent that contains: Methyl Salicylate 25%, Capsaicin 0.025%, Menthol 10%, Lidocaine 2.50%. The MTUS Chronic Pain section notes: Salicylate topical: Recommended. Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain. (Mason-BMJ, 2004) See also Topical analgesics; & Topical analgesics, compounded. Topical. Analgesics: Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, "adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists," agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Capsaicin: Although topical capsaicin has moderate to poor efficacy, it may be particularly useful (alone or in conjunction with other modalities) in patients whose pain has not been controlled successfully with conventional therapy. These agents however are all over the counter; the need for a prescription combination is not validated. The request is appropriately non-certified under MTUS criteria.

18 Chiropractic treatments for right shoulder and wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chiropractic Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

Decision rationale: Manual therapy & manipulation: Recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Forearm, Wrist, & Hand: Not recommended. a. Time to produce effect: 4 to 6 treatments. b. Frequency: 1 to 2 times per week the first 2 weeks, as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. c. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. In these cases, treatment may be continued at 1 treatment every other week until the patient has reached plateau and maintenance treatments have been determined. Extended durations of care beyond what is considered "maximum" may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Such care should be re-evaluated and documented on a monthly basis. Treatment beyond 4-6 visits should be documented with objective improvement in function. Palliative care should be reevaluated and documented at each treatment session. (Colorado, 2006) Injured workers with complicating factors may need more treatment, if documented by the treating physician. The amount requested would be excessive under the guidelines, and was appropriately non certified.

18 Physiotherapy visits for the right shoulder and wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical Medicine Guidelines; Physical Medicine Treatment, Carpal Tunnel (Acute & Chronic), Shoulder.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98.

Decision rationale: The MTUS does permit physical therapy in chronic situations, noting that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The conditions mentioned are Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks; Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks; and Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. This claimant does not have these conditions. And, after several documented sessions of therapy, it is not clear why the patient would not be independent with self-care at this point. In addition, there are especially strong caveats in the MTUS/ACOEM

guidelines against over treatment in the chronic situation supporting the clinical notion that the move to independence and an active, independent home program is clinically in the best interest of the patient. They cite: 1. Although mistreating or under treating pain is of concern, an even greater risk for the physician is over treating the chronic pain patient. Over treatment often results in irreparable harm to the patient's socioeconomic status, home life, personal relationships, and quality of life in general. 2. A patient's complaints of pain should be acknowledged. Patient and clinician should remain focused on the ultimate goal of rehabilitation leading to optimal functional recovery, decreased healthcare utilization, and maximal self actualization. This request for more skilled, monitored therapy was appropriately non-certified.