

Case Number:	CM15-0055023		
Date Assigned:	04/16/2015	Date of Injury:	05/01/2007
Decision Date:	07/22/2015	UR Denial Date:	03/15/2015
Priority:	Standard	Application Received:	03/23/2015

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: New York

Certification(s)/Specialty: Emergency 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 44 year old female, who sustained an industrial injury on May 1, 2007. The injured worker has been treated for neck, bilateral shoulder, bilateral elbow, low back, left knee and bilateral ankle and foot complaints. The diagnoses have included cervical spine herniated nucleus pulposus, cervical radiculopathy, left shoulder sprain/strain, bilateral elbow sprain/strain, low back pain, lumbar spine herniated nucleus pulposus, lumbar radiculopathy, right knee sprain/strain, bilateral ankle sprain/strain, bilateral planter fasciitis, headaches, stress and anxiety. Treatment to date has included medications, radiological studies, acupuncture treatment, chiropractic treatment, shockwave therapy, right shoulder surgery and left knee surgery. Current documentation dated February 6, 2015 notes that the injured worker reported neck, right shoulder, bilateral elbow, low back, left knee and bilateral ankle and foot pain. The injured worker also noted headaches, tooth pain and bleeding gums. Physical examination of the cervical spine, lumbar spine, bilateral shoulders, bilateral elbows, bilateral knees and bilateral ankles revealed tenderness to palpation and a decreased range of motion. The treating physician's plan of care included a request for a XL left knee brace, nerve conduction velocity study/electromyography of the upper extremities, nerve conduction velocity study/electromyography of the lower extremities, Terocin patches, Synapryn, Deprizine, Dicopanol, Fanatrex, Tabradol, Cyclobenzaprine and Ketoprofen cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

XL left knee brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 345-347. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) knee and leg: knee brace.

Decision rationale: According to the Ca MTUS ACOEM guidelines, immobilization is recommended for a short period of time after an acute injury. It is also recommended as a component of a rehabilitation program or for an ACL deficient knee. The ODG guidelines recommend bracing or osteoarthritis, patellar instability, ACL tears or MCL instability. The guidelines further state "In all cases, braces need to be used in conjunction with a rehabilitation program and are necessary only if the patient is going to be stressing the knee under load." The IW does not have any of these supported diagnoses related to the left knee. The request for left knee brace is not medically necessary.

NCV/EMG of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 178 and 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261-262.

Decision rationale: There are no reports from the prescribing physician which adequately present neurologic findings leading to medical necessity for electrodiagnostic testing. Non-specific pain or paresthesias are not an adequate basis for performance of EMG or NCV. Medical necessity for electrodiagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. Non-specific, non-dermatomal extremity symptoms are not sufficient alone to justify electrodiagnostic testing. The MTUS, per the citations listed above, outlines specific indications for electrodiagnostic testing, and these indications are based on specific clinical findings. The physician should provide a diagnosis that is likely based on clinical findings, and reasons why the test is needed. The clinical evaluation is minimal and there is no specific neurological information showing the need for electrodiagnostic testing. Based on the recent clinical information, there are no neurologic abnormalities and no specific neurologic symptoms. Based on the current clinical information, electrodiagnostic testing is not medically necessary, as the treating physician has not provided the specific indications and clinical examination outlined in the MTUS.

NCV/EMG of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 178 and 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 366-367.

Decision rationale: There are no reports from the prescribing physician which adequately present neurologic findings leading to medical necessity for electrodiagnostic testing. Non-specific pain or paresthesias are not an adequate basis for performance of EMG or NCV. Medical necessity for electrodiagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. Non-specific, non-dermatomal extremity symptoms are not sufficient alone to justify electrodiagnostic testing. The MTUS, per the citations listed above, outlines specific indications for electrodiagnostic testing, and these indications are based on specific clinical findings. The physician should provide a diagnosis that is likely based on clinical findings, and reasons why the test is needed. The clinical evaluation is minimal and there is no specific neurological information showing the need for electrodiagnostic testing. Based on the recent clinical information, there are no neurologic abnormalities and no specific neurologic symptoms. Based on the current clinical information, electrodiagnostic testing is not medically necessary, as the treating physician has not provided the specific indications and clinical examination outlined in the MTUS.

Terocin patches: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain; Topical Analgesics Page(s): 60, 111-113.

Decision rationale: The treating physician has not discussed the ingredients of Terocin and the specific indications for this injured worker. Per the manufacturer, Terocin is Methyl Salicylate 25%, Menthol 10%, Capsaicin 0.025%, Lidocaine 2.5%, Aloe, Borage Oil, Boswellia Serrata, and other inactive ingredients. Per page 60 of the MTUS, medications should be trialed one at a time. Regardless of any specific medication contraindications for this patient, the MTUS recommends against starting 3-7 medications simultaneously. Per the MTUS, any compounded product that contains at least one drug that is not recommended is not recommended. Boswellia serrata resin and topical lidocaine other than Lidoderm are "not recommended" per the MTUS. Capsaicin alone in the standard formulation readily available OTC may be indicated for some patients. The indication in this case is unknown, as the patient has not failed adequate trials of other treatments. Capsaicin is also available OTC, and the reason for compounding the formula you have prescribed is not clear. Terocin is not medically necessary based on lack of specific medical indications, the MTUS, lack of medical evidence, FDA directives, and inappropriate prescribing.

Synapryn: 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 <http://www.bioportfolio.com/resources/drug/22213/Synapryn.html>.

Decision rationale: Synapryn is a compounded substance that includes Tramadol as a primary ingredient and typically glucosamine as a second ingredient. While tramadol is discussed in CA MTUS, this compounded formulation is not. ODG is also silent on this substance. Tramadol is a synthetic opioid that is typically prescribed for as needed dosing for pain control. The indications specific to Tramadol are not apparent in chart documentation. The dosing, frequency and effects are not stated. Opioid medication is not supported for use in chronic back pain. The other component, glucosamine, is recommended as an option for the treatment of moderate arthritic pain, mainly the knees. The IW does not have an active diagnosis of arthritis. The combination of these medications is not supported as one is intended for as needed breakthrough pain and carries substantial medical risks due to its potential accumulative effect. The other is for moderate pain caused by osteoarthritis and is used more liberally without the same toxicologic profile. The combination preparation is not supported and therefore, not medically necessary.

Deprizine: 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 NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: Deprizine is the oral solution equivalent of ranitidine. According to CA MTUS, gastrointestinal protectant agents are recommended for patients that are at increased risk for gastrointestinal events. These risks include age >65, history or gastrointestinal bleeding or peptic ulcers, concomitant use of NSAIDs and corticosteroids or aspirin, or high dose NSAID use. The chart does not document any of these risk factors. Past medical history does not include any gastrointestinal disorders, there is no history of poor tolerance to NSAIDs documented and there are not abdominal examinations noted in the chart. Ranitidine is not medically necessary based on the MTUS. Therefore the request is not medically necessary.

Dicopanol: 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 <http://www.drugs.com/pro/dicopanol.html>.

Decision rationale: According to the treating provider's documentation, Dicopanol is a combination of antihistamine and other proprietary ingredients. Unknown components of a medication cannot be evaluated to determine their safety or medical necessity. As such, the request for Dicopanol is not medically necessary.

Fanatrex: 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 <http://www.drugs.com/pro/fanatrex.html>.

Decision rationale: According to the above reference, Fanatrex is a combination of gabapentin and other proprietary ingredients. Unknown components of a medication cannot be evaluated to determine their safety or medical necessity. According to CA MTUS, topical gabapentin is not recommended as there is no peer reviewed literature to support its use. As such, the request for Fanatrex is not medically necessary.

Tabradol: 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 Cyclobenzaprine Page(s): 41-42.

Decision rationale: Tabradol is cyclobenzaprine in an oral suspension. The MTUS for chronic pain does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short-term exacerbations of chronic low back pain. The muscle relaxant prescribed in this case is sedating. The injured worker has chronic pain with no evidence of prescribing for flare-ups. The quantity prescribed implies long term use, not for a short period of use for acute pain. No reports show any specific and significant improvement in pain or function as a result of prescribing muscle relaxants. Per the MTUS chronic pain medical treatment guidelines, cyclobenzaprine (Flexeril, Fexmid, Amrix, Trabadol) is a skeletal muscle relaxant and a central nervous system depressant. It is recommended as an option for a short course of therapy, with greatest effect in the first four days of treatment. Guidelines state that treatment should be brief. Cyclobenzaprine is not recommended to be used for longer than 2-3 weeks. The addition of cyclobenzaprine to other agents is not recommended. Limited, mixed evidence does not allow for a recommendation for chronic use. Therefore the request is not medically necessary.

Cyclobenzaprine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

Decision rationale: According to CA MTUS, cyclobenzaprine is recommended as an option for short course of therapy. Effect is noted to be modest and is greatest in the first 4 days of treatment. The IW has been receiving this prescription for a minimum of 6 months according to submitted records. This greatly exceeds the recommended timeframe of treatment. In addition, the request does not include dosing frequency or duration. The IW's response to this medication is not discussed in the documentation. The request is not medically necessary.

Ketoprofen cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate topicals.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

Decision rationale: Ca MTUS guidelines for topical analgesic agents are referenced above. According to these guidelines, Ketoprofen is not currently FDA approved for topical application. This medication is known to have high incidence of photo-contact dermatitis. As this medication is not supported by the guidelines or FDA approved, the request is determined not medically necessary.