

Case Number:	CM15-0082187		
Date Assigned:	05/04/2015	Date of Injury:	05/24/2007
Decision Date:	09/02/2015	UR Denial Date:	04/09/2015
Priority:	Standard	Application Received:	04/29/2015

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

Certification(s)/Specialty: Anesthesiology, 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:

The injured worker is a 62 year old male who sustained an industrial injury on 05/24/2007. Diagnoses include low back pain, lumbar spine radiculopathy, lumbar spine sprain/strain, lumbar degenerative disc disease, lumbar spine grade 1 spondylolisthesis, lumbar disc displacement herniated nucleus pulposus, status post right knee arthroscopy with residual pain and rule out right knee internal derangement. Treatment to date has included diagnostic studies, status post right knee arthroscopy in 2009, and medications. The physician progress note dated 01/20/2015 documents the injured worker complains of low back pain. The pain was rated as 7-6 out of 10 on the pain analog scale. His pain is constant, moderate to severe. It is associated with numbness and tingling of the right lower extremity. He has right knee pain that he rates as 5 out of 10 on the pain analog scale, and it is constant and moderate to severe. He also complains of numbness, tingling and pain radiating to the foot. His symptoms persist but medications do offer him temporary relief of pain and improve his ability to have a restful sleep. He has an antalgic gait and ambulates with the use of a cane. Lumbar range of motion is restricted. Tripod sign, Flip-test and Lasegue's differential are positive bilaterally. The right knee has crepitus with motion and there is a mild effusion noted at the right knee. There is tenderness to palpation over the medial and lateral joint line. There are some osteophytes noted at the medial joint line at the right knee. Right knee range of motion, flexion is restricted. Treatment requested is for Cyclobenzaprine 5% cream 110gm, Deprizine 5mg/ml 250ml, Dicopanol 5mg/ml 150ml, Fanatrex 25mg/ml 420ml, Ketoprofen 20% cream 167gms, Shockwave Therapy 3 treatments,

Synapryn 10mg/1ml 500ml, Synapryn 10mg/1ml 500ml, and Terocin Patches (quantity unspecified).

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 5% cream 110gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41, 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Muscle relaxants.

Decision rationale: The CA MTUS and the ODG guidelines recommend that muscle relaxants can be utilized for the treatment of exacerbation of musculoskeletal pain that did not respond to standard treatment with NSAIDs and PT. The records did not show that the patient failed standard treatments with oral NSAIDs and co-analgesics. There is lack of guidelines or FDA support for the use of topical formulations of muscle relaxants in the treatment of musculoskeletal pain. The criteria for the use of Cyclobenzaprine 5% 110gm was not met. The request is not medically necessary.

Deprizine 5mg/ml 250ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66.

Decision rationale: The CA MTUS and the ODG guidelines did not recommend the utilization of compound formulations of medications without documentation of objective findings indicating failure of standard formulation of the active agent. The medications contain the H2 antagonist ranitidine as the active ingredient formulated with other compounds that have no guidelines approved indications. The guidelines recommend that medications be utilized individually so that efficacy can be evaluated. The criteria for the use of compounded formulations of ranitidine in the form of Deprizine 5mg/ml 250mg was not met. The request is not medically necessary.

Dicopanol 5mg/ml 150ml: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Institute of Health, <http://www.nim.nih.gov/>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

Decision rationale: The CA MTUS and the ODG guidelines did not recommend the utilization of compound formulations of medications without documentation of objective findings indicating failure of standard formulation of the active agent. The Dicopanol medication contain the antihistamine diphenhydramine as the active ingredient formulated with other compounds that have no guidelines approved indications. The records did not show an indication for the use of antihistamine. The guidelines recommend that medications be utilized individually so that efficacy can be evaluated. The criteria for the use of compounded formulations of diphenhydramine in the form of Dicopanol 5mg/ml 150ml was not met. The request is not medically necessary.

Fanatrex 25mg/ml 420ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 18.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-22.

Decision rationale: The CA MTUS and the ODG guidelines did not recommend the utilization of compound formulations of medications without documentation of objective findings indicating failure of standard formulation of the active agent. The Fanatrex medications contain gabapentin as the active ingredient formulated with other compounds that have no guidelines approved indications. The guidelines recommend that medications be utilized individually so that efficacy can be evaluated. The criteria for the use of compounded formulations of gabapentin in the form of Fanatrex 25mg/ml 420ml was not met. The request is not medically necessary.

Ketoprofen 20% cream 167gms: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-73, 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter NSAIDs.

Decision rationale: The CA MTUS and the ODG guidelines recommend that NSAIDs can be utilized for the treatment of exacerbation of musculoskeletal pain. The chronic use of NSAIDs can be associated with the development of cardiac, renal and gastrointestinal complications. The use of topical NSAIDs can be associated with development of tolerance and decreased efficacy. There is lack of guidelines support for the utilization of topical formulations of ketoprofen which can be associated with the development of photosensitive dermatitis. The criteria for the use of topical ketoprofen 20% 167gm was not met. The request is not medically necessary.

Shockwave Therapy 3 treatments: 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); Treatment Index, 13th Edition (web), 2015, Knee & Leg Chapter, Extracorporeal shock therapy (ESWT).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 171, Chronic Pain Treatment Guidelines Page(s): 118. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Low Back.

Decision rationale: The CA MTUS and the ODG guidelines recommend that stimulating techniques can be utilized for the treatment of musculoskeletal pain. It is recommended that Shockwave treatments be incorporated as part of the PT or physical treatment programs to establish efficacy. The records did not show that the patient had significant beneficial effects during prior trials of shockwave treatments in a PT program. There is documentation that the pain is multifocal in many body regions. The records did not specify the specific location for the shockwave treatments. The criteria for Shockwave Therapy treatments #3 was not met. The request is not medically necessary.

Synapryn 10mg/1ml 500ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 13th Edition (web), 2015, Pain Chapter, Compound drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111, 113, 119. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Opioids.

Decision rationale: The CA MTUS and the ODG guidelines did not recommend the utilization of compound formulations of medications without documentation of objective findings indicating failure of standard formulation of the active agent. The Synapryn medication contain tramadol as the active ingredient formulated with glucosamine and other compounds that have no guidelines approved indications. The guidelines recommend that medications be utilized individually so that efficacy can be evaluated. The guidelines recommend that opioids can be utilized for short term treatment of exacerbation of musculoskeletal pain that did not respond to standard oral NSAIDs and PT. The criteria for the use of compounded formulations of tramadol in the form of Synapryn 10mg/ml 500ml was not met. The request is not medically necessary.

Tabradol 1mg/ml 250ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 13th Edition (web), 2015, Pain Chapter, Compound drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Muscle Relaxants.

Decision rationale: The CA MTUS and the ODG guidelines did not recommend the utilization of compound formulations of medications without documentation of objective findings indicating failure of standard formulation of the active agent. The Tabradol medication contain cyclobenzaprine as the active ingredient formulated with other compounds that have no guidelines approved indications. The guidelines recommend that medications be utilized individually so that efficacy can be evaluated. The patient is utilizing multiple formulations of cyclobenzaprine concurrently. The criteria for the use of compounded formulations of cyclobenzaprine in the form of Tabradol 1mg/ml 250ml was not met. The request is not medically necessary.

Terocin Patches (quantity unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine patch) Page(s): 56 and 57.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Topical Analgesics.

Decision rationale: The CA MTUS and the ODG guidelines recommend that topical analgesics can be utilized for the treatment of localized neuropathic pain that did not respond to standard treatment with standard formulations of first line anticonvulsant and antidepressant medications. The records did not show subjective or objective findings of localized neuropathic pain. There is no documentation of failure of standard formulations of first line medications. The guidelines recommend that topical products be utilized individually so that efficacy can be evaluated. The Terocin product contains menthol 10%/lidocaine 2.5%/capsaicin 0.025%/methyl salicylate 25%. There is lack of guideline support for the utilization of menthol or methyl salicylate for the treatment of chronic musculoskeletal pain. The criteria for the use of Terocin patches was not met. The request is not medically necessary.