

Case Number:	CM14-0099230		
Date Assigned:	08/06/2014	Date of Injury:	02/11/2006
Decision Date:	09/16/2014	UR Denial Date:	05/30/2014
Priority:	Standard	Application Received:	06/27/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations

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 patient with a date of injury of 2/11/06. A utilization review determination dated 5/30/14 recommends non-certification of Synapryn, Tabradol, Deprizine, Dicopanol, Fanatrex, chiropractic manipulation, acupuncture, and Terocin patches. Physical Therapy was modified from an unspecified amount to 6 sessions. It referenced a 4/17/14 medical report identifying low back pain 7-8/10, s/p hardware removal lumbar spine on 4/2/13. There is also right knee pain. She reports feeling anxious and depressed due to her inability to work and perform ADLs. She reports difficulty sleeping. Medications offer temporary pain relief and improve her ability to have restful sleep. On exam, there is tenderness, trigger points, and decreased ROM in the low back. The knee has 1+ effusion, tenderness, 0-120 degrees AROM (Active Range of Motion), positive patellofemoral compression test and Apley's compression test. There is decreased sensation C5-T1 bilaterally, unquantified motor weakness in the upper extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Synapryn 10mg/1ml 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): 50, 76-79.

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, no documentation of knee osteoarthritis, 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 10mg/1ml 500ml is not medically necessary.

Tabradol 1mg/ml 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): 63-66.

Decision rationale: Regarding the request for Tabradol, CA MTUS 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. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the medication. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines, and there is no clear rationale for the use of this oral suspension compounded kit rather than the FDA-approved oral tablet form. In light of the above issues, the currently requested Tabradol 1mg/ml 250ml is not medically necessary.

Deprizine 15mg/ml 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): 68-69 of 127.

Decision rationale: Regarding the request for Deprizine, California MTUS supports H2 blockers 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 medication. Furthermore,

there is no clear rationale for the use of this oral suspension compounded kit rather than the FDA-approved oral tablet form. In light of the above issues, the currently requested Deprizine 15mg/ml 250ml is not medically necessary.

Dicopanol 5mg/ml 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 (ODG) Pain Chapter, Insomnia treatment Other Medical Treatment Guideline or Medical Evidence: <http://www.drugs.com/pro/diphenhydramine-capsules.html>.

Decision rationale: Regarding the request for Dicopanol, California MTUS does not address diphenhydramine. ODG notes that 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. The FDA indications for diphenhydramine include use as an antihistaminic, in the management of motion sickness and Parkinsonism, and as a nighttime sleep-aid. Within the documentation available for review, there is no documentation of any of the abovementioned conditions and a clear rationale for the use of this oral suspension compounded kit rather than the FDA-approved oral capsule form. In light of the above issues, the currently requested Dicopanol 5mg/ml 150ml is not medically necessary.

Fanatrex 25mg/ml 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): 16-21 of 127.

Decision rationale: Regarding request for Fanatrex, CA MTUS Chronic Pain Medical Treatment Guidelines state that antiepilepsy 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 (Antiepilepsy Drugs) depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is no identification of neuropathic pain, any specific analgesic benefit (in terms of percent reduction in pain or reduction of NRS), and specific objective functional improvement. Additionally, there is no clear rationale for the use of this oral suspension compounded kit rather than the FDA-approved oral capsule form. In the absence of such documentation, the currently requested Fanatrex 25mg/ml 420ml is not medically necessary.

Physical Therapy Visits for the right knee and lower back (quantity not specified): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 134, 338.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99 of 127.

Decision rationale: Regarding the request for physical therapy, California MTUS supports up to 10 PT sessions and cites that "patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." Within the documentation available for review, the patient has a longstanding injury, but there is no documentation of specific objective functional improvement with any previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. The previous utilization reviewer modified the request from an unspecified amount of PT to 6 sessions, but unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested physical therapy is not medically necessary.

Chiropractic Manipulation Treatments for the right knee and lower back (quantity not specified): 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): 58-60 of 127.

Decision rationale: Regarding the request for chiropractic manipulation, Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks for the treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. Treatment for the knee is not recommended by the CA MTUS. Within the documentation available for review, while there is some support for a trial of 6 sessions of chiropractic manipulation for low back pain, there is no support for its use in the management of the knee. Furthermore, there is, unfortunately, no provision for modification of the request from an unspecified amount of sessions to the low back and knee to allow for a trial of 6 sessions to the low back only. In light of the above issues, the currently requested chiropractic manipulation is not medically necessary.

Acupuncture Sessions for the right knee and lower back (quantity not specified): Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Regarding the request for acupuncture, California MTUS does support the use of acupuncture for chronic pain, with additional use supported when there is functional improvement documented, which is defined as "either a clinically significant improvement in activities of daily living or a reduction in work restrictions... and a reduction in the dependency on continued medical treatment." A trial of up to 6 sessions is recommended, with up to 24 total sessions supported when there is ongoing evidence of functional improvement. Within the documentation available for review, there is no indication of any prior treatment with acupuncture, but unfortunately, there is no provision for modification of the current request from an unspecified amount to allow for a trial of 6 sessions as supported by the CA MTUS. In light of the above issues, the currently requested acupuncture is not medically necessary.

Terocin Patches (quantity not specified): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112 of 127.

Decision rationale: Regarding the request for Terocin patches, California MTUS notes that topical Lidocaine is "Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica)." Within the documentation available for review, there is no indication of localized peripheral neuropathic pain and failure of first-line therapy. In the absence of such documentation, the currently requested Terocin patches are not medically necessary.