

Case Number:	CM14-0089293		
Date Assigned:	08/08/2014	Date of Injury:	09/27/2008
Decision Date:	09/09/2015	UR Denial Date:	05/29/2014
Priority:	Standard	Application Received:	06/13/2014

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. 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: Internal 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 50 year old male, who sustained an industrial injury on 09/27/2008. He reported injury to his back and head. Treatment to date has included x-rays, physical therapy, acupuncture, extracorporeal shockwave therapy and medications. According to a progress report dated 03/27/2015, the injured worker complained of sharp, burning neck pain and muscle spasms, burning, radicular low back pain and muscle spasms, anxiety and depression. The provider noted that the injured worker had received 3 epidural steroid injections for his lumbar spine with benefit. Medications offered him temporary relief of pain and improved his ability to have a restful sleep. Diagnoses included cervical disc displacement herniated nucleus pulposus, low back pain, lumbar disc displacement herniated nucleus pulposus, radiculopathy lumbar region, anxiety disorder, mood disorder and sleep disorder. Treatment plan included Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclobenzaprine, Ketoprofen cream, shockwave therapy and referral to an orthopedic surgeon. According to an initial pain management consultation dated 04/14/2015, the injured worker experienced ongoing neck pain and stiffness. Pain radiated to both shoulders and upper extremities to the hands with numbness and tingling. He had frequent headaches associated with neck pain. He had difficulty with sleeping. Pain was rated 4-5 on a scale of 1-10. He also reported ongoing low back pain and stiffness. Pain radiated to both hips and buttocks and both lower extremities to the feet with numbness, tingling and weakness. Pain was rated 5 on a scale of 1-10 and with activity pain was rated 7. Diagnoses included multiple level cervical disc protrusion, cervical radiculopathy and lumbosacral sprain/strain with radiculopathy. The provider discussed the option of a cervical epidural steroid

injection but the injured worker stated that he had undergone this procedure over the lumbar spine area without any benefit and therefore was not considering any type of such same procedure. Currently under review is the request for Synapryn, Tabradol, Deprizine, Dicopanol, Fanatrex, 6 Localized Intense Neurostimulation Therapy (LINT) sessions, unknown prescription of Terocin patch, 1 lumbar epidural steroid injection, 1 pain management consultation and a urine drug screen on 04/14/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Synapryn 10mg//1ml 500ml, #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Not addressed. Decision based on Non-MTUS Citation <http://dailymed.nlm.nih.gov>.

Decision rationale: Synapryn is a compounding kit for oral suspension of Tramadol and Glucosamine. Established guidelines show no evidence-based support for the use of oral suspension or compounded form of these medications and documentation fails to show that the injured worker has a condition that would require an oral suspension of medications already available in pill form. The request for Synapryn 10mg//1ml 500ml, #1 is not medically necessary.

Tabradol 1mg/ml 250ml, #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Not addressed. Decision based on Non-MTUS Citation <http://www.drugs.com>.

Decision rationale: Tabradol is a compounding kit for oral suspension of Cyclobenzaprine and Methylsulfonylmethane. Established guidelines show no evidence-based support for the use of oral suspension or compounded form of these medications and documentation fails to show that the injured worker has a condition that would require an oral suspension of medications already available in pill form. The request for Tabradol 1mg/ml 250ml, #1 is not medically necessary.

Deprizine 15 mg/ml oral suspension 250ml, #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Not addressed. Decision based on Non-MTUS Citation <http://www.drugs.com/pro/deprizine.html>.

Decision rationale: Deprizine is a compounding kit for oral suspension of Ranitidine. Documentation fails to provide support that the injured worker has a condition that would require an oral suspension of this medication and established guidelines do not support the use of Deprizine. The request for Deprizine 15 mg/ml oral suspension 250ml, #1 is not medically necessary.

Dicopanol 5 mg/ml 150ml, #1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Insomnia.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Not addressed. Decision based on Non-MTUS Citation <http://dailymed.nlm.nih.gov>.

Decision rationale: Dicopanol is a compounded version of Diphenhydramine. Documentation fails to provide support that the injured worker has a condition that would require a compounded form when the medication is available in pill form. Established guidelines do not recommend Dicopanol. The request for Dicopanol 5 mg/ml 150ml, #1 is not medically necessary.

Fanatrex 25mg/ml 420 ml, #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Not addressed. Decision based on Non-MTUS Citation <http://www.drugs.com>.

Decision rationale: Fanatrex is a compounding kit for oral suspension of Gabapentin. Established guidelines show no evidence-based support for the use of oral suspension of Gabapentin and documentation fails to show that the injured worker has a condition that would require a compounded form when the medication is available in pill form. The request for Fanatrex 25mg/ml 420 ml, #1 is not medically necessary.

6 localized intense neurostimulation therapy sessions (LINT): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 308.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Not addressed. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Hyperstimulation Analgesia.

Decision rationale: ODG states that localized intense Neurostimulating therapy (LINT), a procedure usually described as hyperstimulation analgesia, has been investigated in several

controlled studies, but is not recommended until there are higher quality studies. Localized manual high-intensity neurostimulation devices are used to apply localized, intense, low-rate electrical pulses to painful active myofascial trigger points. The request for 6 localized intense neurostimulation therapy sessions (LINT) is not medically necessary due to lack of sufficient evidence to recommend its use as per ODG.

Unknown prescription of Terocin Patch: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: MTUS states that use of topical analgesics is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Terocin is a topical analgesic containing Lidocaine and Menthol. MTUS provides no evidence recommending the use of topical Menthol. Per guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request for Unknown prescription of Terocin Patch is not medically necessary.

1 Lumbar Epidural Steroid Injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of epidural steroid injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: MTUS recommends Epidural steroid injections (ESIs) as an option for short-term treatment of radicular pain, in conjunction with other rehabilitation efforts, including continuing a home exercise program. The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. Per MTUS, radiculopathy must be documented by physical examination and corroborated by imaging. No more than 2 Epidural steroid injections are recommended per current guidelines. The injured worker complains of chronic radicular low back pain. Physician report at the time of request under review indicates that two Epidural injections have been performed to date, with benefit. Documentation reviewed however fails to show demonstrable improvement in pain and function, and per guidelines, no more than two epidural steroid injections are recommended. The request for 1 Lumbar Epidural Steroid Injection is not medically necessary by MTUS.

1 Pain Management Consultation: 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 Chronic pain programs (functional restoration programs) Page(s): 30- 33, pg 49.

Decision rationale: Multidisciplinary pain programs or Interdisciplinary rehabilitation programs combine multiple treatments, including physical treatment, medical care and supervision, psychological and behavioral care, psychosocial care, vocational rehabilitation and training and education. Per MTUS guidelines, Outpatient pain rehabilitation programs may be recommended if previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement, if the patient has a significant loss of ability to function independently resulting from the chronic pain and if the patient is not a candidate where surgery or other treatments would clearly be warranted. Documentation shows that Pain Management Consultation is being requested for Epidural Steroid injection. With the procedure not having been approved, the recommendation for Pain Management Consultation is no longer indicated. The request for 1 Pain Management Consultation is not medically necessary.

Urine drug screen 4/14/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, differentiation: dependence & addiction Page(s): 85. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids, Urine drug tests.

Decision rationale: MTUS recommends screening patients to differentiate between dependence and addiction to opioids. Frequency of urine drug testing should be based on documented evidence of risk stratification. Patients at "low risk" of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. Random collection is recommended. Quantitative urine drug testing is not recommended for verifying compliance without evidence of necessity. Documentation fails to demonstrate that the injured worker is at high risk of addiction or aberrant behavior and there is no evidence that an Opioid drug is being prescribed. With guidelines not being met, the request for Urine drug screen 4/14/2014 is not medically necessary.