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| Case Number: | CM15-0120886 | | |
| Date Assigned: | 07/29/2015 | Date of Injury: | 06/28/2014 |
| Decision Date: | 09/17/2015 | UR Denial Date: | 05/22/2015 |
| Priority: | Standard | Application Received: | 06/23/2015 |

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 male, who sustained an industrial injury on 06-28-14. He has reported subsequent neck pain and muscle spasms, numbness and tingling of the bilateral upper extremities, bilateral wrist pain and spasms, low back pain with muscle spasms and associated numbness and tingling of the lower extremities and was diagnosed with cervical and lumbar sprain/strain, cervical spine radiculopathy, bilateral wrist carpal tunnel syndrome, low back pain and lower extremity radiculitis. Other diagnoses included anxiety, stress and sleep disorder. Treatment to date has included medication. In a progress note dated 05/20/2015, the injured worker reported low back pain with radiation to the bilateral lower extremities. Objective findings were notable for pain and myospasm to palpation of the bilateral lumbar paravertebral muscles, pain to palpation of the bilateral sacroiliac joint, decreased lumbar range of motion, positive bilateral Kemp's test for lumbar pain, positive bilateral FABERE test and positive bilateral Yeoman's test. Work status was temporarily totally disabled. A request for authorization of shockwave therapy to the cervical and lumbar spine, 6 treatments between 3-26-2015 and 6-26-2015, Terocin patches, unknown, functional capacity evaluation, Deprixine 250 ml, Dicopanol 150 ml between 3-26-2015 and 6-26-2015, Fanatrex 420 ml between 3-26-2015 and 6-26-2015, Synapryn 500 ml between 3-26-2015 and 6-26-2015 and Tabradol 250 ml between 3-26-2015 and 6-26-2015 was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shockwave therapy - cervical and lumbar spine, 6 treatments between 3/26/15 and 6/26/15:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) Chapter, Extracorporeal Shockwave Therapy.

Decision rationale: MTUS is silent regarding the use of shockwave therapy for the neck and low back so alternative guidelines were referenced. As per ODG, shockwave therapy is not recommended for back pain as the available evidence does not support its' effectiveness. There is no guideline support for the use of shockwave therapy for neck pain. Therefore, the request for shockwave therapy to the neck and low back is not medically necessary.

Terocin patches-unknown: Upheld

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

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

Decision rationale: There is no documentation provided necessitating the use of the requested topical medication, Terocin. According to the CA MTUS Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, Capsaicin, local anesthetics or antidepressants. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case there is no documentation provided necessitating Terocin. This medication contains methyl salicylate, capsaicin, menthol, and lidocaine. MTUS states that Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Lidocaine is only approved in the formulation of a dermal patch. There is no documentation of intolerance to other previous medications and there is no documentation of a failure of first line therapeutic agents. In addition, there was no dosage, frequency, site of application or instructions for use listed. Medical necessity for the requested topical medication has not been established. The requested treatment is not medically necessary.

Functional capacity 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness For Duty Chapter, Functional Capacity Evaluation (FCE).

Decision rationale: CA MTUS is silent regarding functional capacity evaluations so alternative guidelines were referenced. As per ODG, a functional capacity evaluation (FCE) is recommended prior to admission to a work hardening program and is not recommended for routine use as part of occupational rehabilitation or screening or generic assessments to ascertain whether someone can do any type of job generally. ODG further indicates that an FCE can be considered if case management is hampered by issues such as prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modified job or injuries that require detailed exploration of a worker's abilities and timing is appropriate such as when the injured worker is close to or at maximal medical improvement and all key reports are secured and if additional or secondary conditions are clarified. FCE should not be performed solely to determine the injured worker's effort or compliance or if the worker has returned to work and an ergonomic assessment has not been arranged. There is no evidence in the submitted documentation that shows that the injured worker was being considered for enrollment in a work hardening program. There don't appear to be any complex issues hampering case management and the timing doesn't appear appropriate. Therefore, the request for authorization is not medically necessary.

Deprizine 250 ml: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Up to Date.

Decision rationale: Deprizine (Ranitidine) oral suspension is a histamine blocker and antacid used to treat peptic ulcers, gastritis and gastro-esophageal reflux (GERD). Ranitidine works by blocking the effects of histamine on the receptor site known as H2. Proton Pump Inhibitors (PPI's) are prescribed to prevent and treat ulcers in the duodenum (where most ulcers develop) and the stomach. Deprizine oral suspension is a suspension consisting of undissolved particles of one or more medicinal agents mixed with a liquid vehicle for oral administration. Evidence-based guidelines and peer-reviewed medical literature do not address the use of medications in oral suspension form. Oral suspensions of medications are generally for use in patients for whom taking the pill/tablet form of the medication is either impractical or unsafe. In this case, there is no documentation in the medical records of any conditions that would preclude the use of medications in their pill/tablet form. In addition, there is no documentation of abnormal subjective or objective gastrointestinal examination findings. Medical necessity of the Deprizine (Ranitidine) oral suspension has not been established. The requested medication is not medically necessary.

Dicopanol 150 ml between 3/26/15 and 6/26/15: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Up to Date.

Decision rationale: Dicopanol, the oral suspension form of Diphenhydramine, is an antihistamine that is used for the temporary relief of seasonal and perennial allergy symptoms. The medication is sedating and has been used for short-term treatment of insomnia. The physician noted in the request for authorization that the injured worker had a history of an irregular sleeping pattern and was diagnosed with mild to moderate insomnia. Progress notes noted insomnia due to chronic pain but there were no specifics given regarding the nature of the injured worker's sleep issues in the submitted progress notes. Dicopanol is generally for use in patients for whom taking the pill/tablet form of the medication is either impractical or unsafe. In this case, there was no documentation in the medical records of any conditions that would preclude the use of medications in their pill/tablet form. In addition, this medication had been prescribed since at least 02/26/2015 and there was no documentation of any significant symptom relief or functional improvement with use of the medication. Medical necessity for the requested oral suspension medication was not established. The requested medication was not medically necessary.

Fanatrex 420 ml between 3/26/15 and 6/26/15: 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 Anti-Epilepsy Drugs Page(s): 16-22. Decision based on Non-MTUS Citation Up to Date.

Decision rationale: According to the CA MTUS, Fanatrex oral suspension (Gabapentin) is an anti-epilepsy drug, which has been considered a first-line treatment for neuropathic pain. Synapryn had been prescribed since at least 02/26/2015 and there was no documentation of objective functional improvement with use of the medication. Work status remained temporarily totally disabled. An oral suspension is a suspension consisting of undissolved particles of one or more medicinal agents mixed with a liquid vehicle for oral administration. Evidence-based guidelines and peer-reviewed medical literature do not address the use of medications in oral suspension form. Oral suspensions of medications are generally for use in patients for whom taking the pill/tablet form of the medication is either impractical or unsafe. In this case, there is no documentation in the medical records of any conditions that would preclude the use of medications in their pill/tablet form. Medical necessity for the requested medication, Fanatrex has not been established. The requested medication is not medically necessary.

Synapryn 500 ml between 3/26/15 and 6/26/15: 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 Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Up to Date.

Decision rationale: According to the CA MTUS, Synapryn oral suspension (Tramadol hydrochloride) is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. Synapryn had been prescribed since at least 02/26/2015 and there was no documentation of objective functional improvement with use of the medication. Work status remained temporarily totally disabled. The least and average amount of pain were not rated and the duration of pain relief was not documented. An oral suspension is a suspension consisting of undissolved particles of one or more medicinal agents mixed with a liquid vehicle for oral administration. Evidence-based guidelines and peer-reviewed medical literature do not address the use of medications in oral suspension form. Oral suspensions of medications are generally for use in patients for whom taking the pill/tablet form of the medication is either impractical or unsafe. In this case, there is no documentation in the medical records of any conditions that would preclude the use of medications in their pill/tablet form. Medical necessity for the requested Synapryn oral suspension has not been established. Of note, discontinuation of an opioid analgesic requires a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

Tabradol 250 ml between 3/26/15 and 6/26/15: 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 Muscle Relaxants Page(s): 63-66. Decision based on Non-MTUS Citation Up to Date.

Decision rationale: According to the reviewed literature, Tabradol (Cyclobenzaprine) oral suspension is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. According to CA MTUS guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. Tabradol was prescribed since at least 02/26/2015 and there was no documentation of objective functional improvement with use of the medication. Work status remained temporarily totally disabled. Tabradol oral suspension is a suspension consisting of undissolved particles of one or more medicinal agents mixed with a liquid vehicle for oral administration. Evidence-based guidelines and peer-reviewed medical literature do not address the use of medications in oral suspension form. Oral suspensions of medications are generally for use in patients for whom taking the pill/tablet form of the medication is either impractical or

unsafe. In this case, there is no documentation in the medical records of any conditions that would preclude the use of medications in their pill/tablet form. The injured worker was concurrently prescribed oral Cyclobenzaprine and there is no indication as to why the injured worker would need two different formulations of this medication. Based on the currently available information, the medical necessity for Tabradol oral suspension has not been established. The requested medication is not medically necessary.