

Case Number:	CM15-0128995		
Date Assigned:	08/03/2015	Date of Injury:	03/06/2014
Decision Date:	09/15/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	07/02/2015

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: Pediatrics, 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 31 year old male, who sustained an industrial injury on 03-06-2014. He has reported subsequent low back pain radiating to the legs, numbness and tingling of the bilateral lower extremities and left shoulder pain and was diagnosed with left shoulder sprain and strain rule out internal derangement and lumbar spine sprain and strain rule out herniated nucleus pulposus. Treatment to date has included medication, physical therapy, chiropractic therapy and acupuncture. In a progress note dated 06-08-2015, the injured worker reported left shoulder and low back pain radiating to the bilateral lower extremities associated with numbness and tingling. Objective findings were notable for tenderness to palpation and reduced range of motion of the left shoulder and lumbar spine and slightly diminished sensation to pinprick and light touch over the C5-C8 and T1 dermatomes in the bilateral upper extremities. Work status was temporarily totally disabled. A request for authorization of unknown prescription of Terocin patches, Ketoprofen 20% gel 167 g, Cyclobenzaprine 5% gel 110 g, Synapryn 10 mg per 1 ml (500 ml), Tabradol 1 mg per ml (250 ml), Deprizine 15 mg per ml (250 ml), Dicopanol 5 mg per ml (150 ml), Fanatrex 25 mg per ml (420 ml) and a urine drug screen was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Unknown prescription of Terocin patches: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical medications-Lidocaine, topical.

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

Decision rationale: According to the California MTUS Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of anti-depressants and anti-convulsants 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 anti-depressants. 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. There is no documentation of intolerance to other previous medications. Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. In addition, this medication had been prescribed since at least 01-20-2015 and there was no documentation of significant pain reduction or objective functional improvement. There was no documentation of a return to work and no significant change in pain ratings was documented. Medical necessity for the requested topical medication has not been established. The requested treatment is not medically necessary.

Ketoprofen 20% gel 167g: 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): 111-113.

Decision rationale: According to CA MTUS guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of anti-depressants and anti-convulsants 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. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. Ketoprofen is not currently FDA approved for a topical application, and has an extremely high incidence of photo contact dermatitis. In addition, there is no indication that the injured worker had failed a course of first line therapeutic agents. Therefore, the request is not medically necessary.

Cyclobenzaprine 5% gel 110g: Upheld

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

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

Decision rationale: According to CA MTUS guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of anti-depressants and anti-convulsants 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. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. Cyclobenzaprine is not FDA approved for use as a topical application. There is no evidence for the use of any muscle relaxant as a topical agent. In addition, there is no indication that the injured worker had failed a course of first line therapeutic agents. Therefore, the request is not medically necessary.

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 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. This medication had been prescribed since at least 01-20-2015 and there was no documentation of the duration of pain relief and no evidence of significant pain reduction or functional improvement. Work status remained temporarily totally disabled and pain remained unchanged despite use of the medication. 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 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 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. This medication had been prescribed since at least 01-20-2015 and there was no evidence of significant pain reduction or functional improvement. Work status remained temporarily totally disabled and there was no documentation of significant pain reduction despite use of the 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.

Deprizine 15mg/ml 250ml: 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 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. In addition, there was no documentation of abnormal gastrointestinal examination findings or risk factors for gastrointestinal issues. Medical necessity of the Deprizine (Ranitidine) oral suspension has not been established. The requested medication 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 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 did document that the injured worker has a history of insomnia but no further specifics were given regarding the nature of the sleep difficulties. Medical necessity for the requested oral suspension medication was not established. The requested medication was 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 Anti-Epilepsy Drugs Page(s): 16-22.

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. This medication was prescribed since at least 01-20-2015 and there is no documentation of significant pain reduction or objective functional improvement. There was no significant reduction of pain, there was no return to work documented and no documentation of improved quality of life. Medical necessity for the requested medication, Fanatrex has not been established. The requested medication is not medically necessary.

Urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of urine drug testing. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic): Urine Drug Test (UDT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter, Urine Drug Testing.

Decision rationale: As per CA MTUS guidelines, for ongoing management of patients prescribed opioid medication, random frequent urine drug screens is one step to avoid misuse of opioids, especially for those at high risk of abuse. As per ODG, urine drug testing is recommended to monitor compliance with prescribed medication, identify the use of undisclosed substances and identify possible diversion. Urine drug testing is recommended at the start of treatment in a new patient who is already taking a controlled substance, when chronic opioid management is considered, in cases where a patient asks for a specific drug, if the patient has a positive or at risk addiction screen, or if aberrant behavior or misuse is suspected or detected. There is no indication that the injured worker was currently prescribed any medications for which testing would be warranted nor was there evidence of drug misuse, abuse or dependence in the submitted documentation. There is no indication that the injured worker was asking for a specific drug or that there was a history of substance abuse or a positive risk screen addiction. The documentation is insufficient to establish the medical necessity of the requested service. Therefore, the request for urine toxicology is not medically necessary.