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| Case Number: | CM15-0141212 | | |
| Date Assigned: | 08/21/2015 | Date of Injury: | 09/27/2012 |
| Decision Date: | 10/13/2015 | UR Denial Date: | 06/17/2015 |
| Priority: | Standard | Application Received: | 07/21/2015 |

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: California

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 35 year old male, who sustained an industrial injury on September 27, 2012, incurring right hand injuries. He was diagnosed with a right wrist sprain, and right little finger ligament tear. Treatment included pain medications, anti-inflammatory drugs, sleep aides, neuropathic medications, antidepressants, muscle relaxants, and activity restrictions with work modifications. Currently, the injured worker complained of constant residual sharp pain of the right hand fifth digit post-surgery. The pain was aggravated by gripping, grasping, reaching, pulling and lifting. He complained of weakness and numbness of the hand and fingers and restricted range of motion. He noted feelings of anxiety and depression due to his chronic pain and the inability to return to work. He had difficulty sleeping secondary to the pain. The treatment plan that was requested for authorization included physical therapy for the right hand, acupuncture sessions for the right little finger and right ring finger and prescriptions for Synapryn, Tabradol, Deprizine, Dicopanor, Fanatrex, Ketoprofen cream and Cyclobenzaprine cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy (right hand/ring finger) 3x6 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: The request is for physical therapy to aid in pain relief. The MTUS guidelines states that manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. It is indicated for low back pain but not ankle and foot conditions, carpal tunnel syndrome, forearm/wrist/hand pain, or knee pain. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases. In this case, the patient would benefit most from at home active therapy. As such, the request is not certified.

Acupuncture sessions (right hand/ring finger) 3x6 weeks: 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 Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic)/Acupuncture.

Decision rationale: The request is for acupuncture. The Official Disability Guidelines state the following regarding this topic: Not recommended. Rarely used and recent systematic reviews do not recommend acupuncture when compared to placebo or control. (Gerritsen, 2002) (O'Conner-Cochrane, 2003) (Goodyear-Smith, 2004) For an overview of acupuncture and other conditions in which this modality is recommended see the Pain Chapter. In this case, the request is not indicated. This is secondary to inadequate clinical evidence regarding effectiveness. As such, the request is not certified.

Synapryn: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The request is for the use of a topical lidocaine patch to aid in pain relief. The MTUS guidelines state that its use is indicated for post herpetic neuralgia after an initial trial of an anti-epileptic medication. Further research is needed to recommend use for chronic neuropathic disorders besides post-herpetic neuralgia. In this case, the patient does not have a diagnosis documented, which would justify the use of topical lidocaine patches. As such, the request is not certified.

Tabradol: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: The request is for the use of a muscle relaxant to aid in pain relief. The MTUS guidelines state that the use of a medication in this class is indicated as a second-line option for short-term treatment of acute exacerbations of low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, which can increase mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain improvement. Efficacy appears to diminish over time, and prolonged use may lead to dependence. (Homik, 2004) Due to inadequate qualifying evidence and prolonged duration of use, the request is not certified. All muscle relaxant medications should be titrated down slowly to prevent an acute withdrawal syndrome.

Deprizine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: The request is for the use of a medication in the class of an acid reducing medication. The guidelines do not specifically address or advise the use of an H2 blocker but does make recommendations regarding medications in the same category classified as proton pump inhibitors. This is usually given for patients with esophageal reflux, gastritis, or peptic ulcer disease. It can also be used as a preventative measure in patients taking non-steroidal anti-inflammatories for chronic pain which have side effects including gastrointestinal disease. The MTUS guidelines states that patients who are classified as intermediate or high risk, should be treated prophylactically with a proton pump inhibitor or Misoprostol. Criteria for risk are as follows: "(1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)." Due to the fact the patient does not meet to above stated criteria, the request for use is not certified.

Dicopanol (Diphenhydramine): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MD Consult Drug Monograph last updated 12/31/2011.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress/Diphenhydramine (Benadryl).

Decision rationale: The request is for the use of Diphenhydramine, which is in the category of an antihistamine. The MTUS guidelines are silent regarding this topic. The ODG states the following regarding its use: Not recommended. See Insomnia treatment, where sedating antihistamines are not recommended for long-term insomnia treatment. The AGS updated Beers criteria for inappropriate medication use includes diphenhydramine. (AGS, 2012)

Anticholinergic drugs, including diphenhydramine, may increase the risk for dementia by 50% in older adults. There is an obvious dose-response relationship between anticholinergic drug use and risk of developing dementia, but chronic use, even at low doses, would be in the highest risk category. While there is awareness that these drugs may cause short-term drowsiness or confusion, which is included in the prescribing information, there is no mention of long-term effects on cognition, and generally awareness of this issue is very low, and both the public and doctors need to be encouraged to use alternative treatments where possible. (Gray, 2015) As stated above, the use of this medication is not indicated for use in this patient for insomnia. There is inadequate documentation of the reasoning for its use for other indications. As such, the request is not certified.

Fanatrex (Gabapentin): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: The request is for the use of a medication in the category of an anti-epileptic drug (AED). These medications are recommended for certain types of neuropathic pain. Most of the randomized clinical control trials involved include post-herpetic neuralgia and painful polyneuropathy such as in diabetes. There are few trials, which have studied central pain or radiculopathy. The MTUS guidelines state that a good response to treatment is 50% reduction in pain. At least a 30% reduction in pain is required for ongoing use, and if this is not seen, this should trigger a change in therapy. There also should be documentation of functional improvement and side effects incurred with use. Disease states, which prompt use of these medications, include post-herpetic neuralgia, spinal cord injury, chronic regional pain syndrome, lumbar spinal stenosis, post-operative pain, and central pain. There is inadequate evidence to support use in non-specific axial low back pain or myofascial pain. In this case, there is lack of documentation of adequate pain reduction for continued use. The records also do not reveal functional improvement or screening measures as required. As such, the request is not certified.

Ketoprofen 20% cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The request is for the use of a topical NSAID for pain relief. There are specific criteria required for use based on the guidelines. The MTUS states the following: The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a

diminishing effect over another 2-week period. (Lin, 2004) (Bjordal, 2007) (Mason, 2004) When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. FDA-approved agents: Voltaren Gel 1% (Diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. In this case, as indicated above, the patient would not qualify for the use of this medication based on the treatment duration. As such, the request is not certified.

Cyclobenzaprine 5% cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients, which each have specific properties and mechanisms of action. The MTUS guidelines state the following: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, the use of the topical muscle relaxant is not indicated for use for the patient's condition. The MTUS states the following: "There is no evidence for use of any other muscle relaxant as a topical product." As such, the request is not certified.

Physical therapy for the right little finger (pinky), 3x6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers' Compensation (ODG-TWC), Forearm, Wrist & Hand Procedure Summary online version.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: The request is for physical therapy to aid in pain relief. The MTUS guidelines states that manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. It is indicated for low back pain but not ankle and foot conditions, carpal tunnel syndrome, forearm/wrist/hand pain, or knee pain. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases. In this case, the patient would benefit most from at home active therapy. As such, the request is not certified.

Acupuncture sessions for the right little finger (pinky), 3x6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic)/Acupuncture.

Decision rationale: The request is for acupuncture. The Official Disability Guidelines state the following regarding this topic: Not recommended. Rarely used and recent systematic reviews do not recommend acupuncture when compared to placebo or control. (Gerritsen, 2002) (O'Conner-Cochrane, 2003) (Goodyear-Smith, 2004) For an overview of acupuncture and other conditions in which this modality is recommended see the Pain Chapter. In this case, the request is not indicated. This is secondary to inadequate clinical evidence regarding effectiveness. As such, the request is not certified.