

Case Number:	CM15-0166910		
Date Assigned:	09/30/2015	Date of Injury:	05/30/2013
Decision Date:	12/01/2015	UR Denial Date:	07/21/2015
Priority:	Standard	Application Received:	08/25/2015

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: 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 54 year old male who sustained an industrial injury on 5-30-13 from a trip and fall injuring his lower left leg and lower back. The medical records indicate that the injured worker was being treated for lumbar disc displacement; lumbar radiculopathy; unilateral posttraumatic osteoarthritis, left knee; derangement of the posterior horn of the medial and lateral meniscus, rule out tear, left knee; left lower extremity pain and swelling; sleep disorder; wrist tendinitis, bursitis. He currently (8-4-15) complains of burning radicular low back pain radiating down the left leg to the bottom of the foot and great toe and muscle spasms with a pain level of 3 out of 10; burning left knee pain and muscle spasms with numbness, tingling and pain radiating to the foot, his knee also gives way causing him to fall; constant, burning and swelling of the left leg to the ankle with a pain level of 3 out of 10. He has sleep difficulties due to pain. Medications offer temporary relief and enable him to have a restful sleep. On physical exam of the lumbar spine he was able to heel-toe walk with pain at the lower back and left buttock, there was tenderness to palpation with trigger point noted on the left side and tenderness over the lumbosacral junction at the left sciatic notch, there was decreased range of motion, tripod, flip test and laseque's were positive bilaterally; left knee had 1+ effusion, range of motion was decreased tenderness to palpation with patella-femoral crepittance, decreased range of motion, sensation. His pain levels ranged from 3-7 out of 10 from 1-2015 through 8-4-15. Diagnostics included MRI of the lumbar spine (8-6-13); MRI of the left knee (8-6-13). Treatments to date include physical therapy; acupuncture with benefit; lumbar spine brace; knee brace; chiropractic therapy; 1 lumbar epidural injection (3-22-14) with temporary relief; cortisone injection left

knee; medications: Ketoprofen 20% cream, 167 grams and records indicate he has been on this since 7-18-13; cyclobenzaprine 5% cream, 110 grams; Synapryn 10mg.per milliliter, 500 milliliters; tabradol 1 mg per milliliter, 250 milliliters; deprizine 15 mg per milliliter, 250 milliliters; dicopanol 5 mg per milliliter, 150 milliliters; Fanatrex 25 mg per milliliter, 420 milliliters. He has been on the medications since at least 1-2015. The request for authorization dated 8-4-15 was for Ketoprofen 20% cream, 167 grams; cyclobenzaprine 5% cream, 110 grams; Synapryn 10mg.per milliliter, 500 milliliters; tabradol 1 mg per milliliter, 250 milliliters; deprizine 15 mg per milliliter, 250 milliliters; dicopanol 5 mg per milliliter, 150 milliliters; Fanatrex 25 mg per milliliter, 420 milliliters; consultation with pain management specialist regarding epidural steroid injections for the lumbar spine; shockwave therapy times 6 for the lumbar spine; shockwave therapy times 3 for the left knee; localized intense neurostimulation therapy to the lumbar spine with unknown sessions. On 7-21-15 Utilization Review non-certified the requests for Ketoprofen 20% cream, 167 grams; cyclobenzaprine 5% cream, 110 grams; Synapryn 10mg.per milliliter, 500 milliliters; tabradol 1 mg per milliliter, 250 milliliters; deprizine 15 mg per milliliter, 250 milliliters; dicopanol 5 mg per milliliter, 150 milliliters; Fanatrex 25 mg per milliliter, 420 milliliters; consultation with pain management specialist regarding epidural steroid injections for the lumbar spine; shockwave therapy times 6 for the lumbar spine; shockwave therapy times 3 for the left knee; localized intense neurostimulation therapy to the lumbar spine with unknown sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 20% cream 167gm: 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: MTUS states that topical NSAIDs are not recommended for neuropathic pain, but may be useful for short-term treatment (4-12 weeks) of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) . Topical NSAIDS have not been evaluated for treatment of the spine, hip or shoulder. There are no long-term studies of their effectiveness or safety. Per MTUS, Ketoprofen is not recommended and is not currently FDA approved for a topical application. The request for Ketoprofen 20% cream 167gm is therefore not medically necessary.

Cyclobenzaprine 5% cream 110gm: 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: 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. MTUS does not recommend the use of muscle relaxants as a topical agent. Per guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request for Cyclobenzaprine 5% cream 110gm is not medically necessary.

Synapryn 10gm/1ml oral suspension 500ml: 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 www.dailymed.nlm.nih.gov.

Decision rationale: MTUS does not address this request. 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 10gm/1ml oral suspension 500ml is not medically necessary.

Tabradol 1mg/ml oral suspension 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 www.drugs.com.

Decision rationale: MTUS does not address this request. 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 oral suspension 250ml is not medically necessary.

Deprizine 15mg/ml oral suspension 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 www.drugs.com/pro/deprizine.html.

Decision rationale: MTUS does not address this request. 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 15mg/ml oral suspension 250ml is not medically necessary.

Dicopanol 5mg/ml oral suspension 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 www.dailymed.nlm.nih.gov.

Decision rationale: MTUS does not address this request. 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 5mg/ml oral suspension 150ml is not medically necessary.

Fanatrex 25mg/ml oral suspension 420ml: 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 www.drugs.com.

Decision rationale: MTUS does not address this request. 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 oral suspension 420ml is not medically necessary.

Consultation with pain management specialist regarding epidural steroid injections for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Chronic Pain Disorder Medical Treatment Guidelines, State of Colorado Department of Labor and Employment, 4/27/2007 page 56.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Cornerstones of Disability Prevention and Management, and Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: MTUS, ACOEM, Chapter 5, Disability, Referrals, pg 92. MTUS states that a referral may be appropriate if the practitioner is uncomfortable with treating a particular cause of delayed recovery or has difficulty obtaining information or agreement to a treatment plan. Depending on the issue involved, it often is helpful to "position" a behavioral health evaluation as a return-to-work evaluation. The goal of such an evaluation is functional recovery and return to work. 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. A second epidural injection may be performed if there is partial success produced with the first injection, based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks. The injured worker complains of chronic low back pain with no documentation of lasting objective improvement in pain or function with previous Epidural Steroid injection. The medical necessity for repeat Epidural Steroid injection has not been established. The request for Consultation with pain management specialist regarding epidural steroid injections for the lumbar spine is not medically necessary.

Shockwave therapy x6 for the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back-Lumbar & Thoracic (Acute & Chronic): Extracorporeal shock wave therapy (ESWT), 2015.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Extracorporeal shock wave therapy (ESWT).

Decision rationale: MTUS does not address this request. Per guidelines, Extracorporeal Shockwave Treatment (ESWT) is approved for the treatment of Rotator cuff tendonitis associated with calcific deposits in the tendon (calcific tendonitis). It is recommended for use in patients, whose pain has remained despite six months of standard treatment and at least three conservative treatments, including rest, Ice, NSAIDs, Orthotics, Physical Therapy and Cortisone injections. The injured worker complains of chronic radicular low back pain. Documentation fails to demonstrate a diagnosis that fits the criteria for the recommendation of extracorporeal shock wave therapy (ESWT). The request for Shockwave therapy x6 for the lumbar spine is not medically necessary per guidelines.

Shockwave therapy x3 for the left knee: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Knee & Leg (Acute & Chronic): Extracorporeal shock wave therapy (ESWT), 2015.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Extracorporeal shock wave therapy (ESWT).

Decision rationale: MTUS does not address this request. Per guidelines, Extracorporeal Shockwave Treatment (ESWT) is approved for the treatment of Rotator cuff tendonitis associated with calcific deposits in the tendon (calcific tendonitis). It is recommended for use in patients, whose pain has remained despite six months of standard treatment and at least three conservative treatments, including rest, Ice, NSAIDs, Orthotics, Physical Therapy and Cortisone injections. The injured worker complains of chronic left knee pain. Documentation fails to demonstrate a diagnosis that fits the criteria for the recommendation of extracorporeal shock wave therapy (ESWT). The request for Shockwave therapy x3 for the left knee is not medically necessary per guidelines.

Localized intense neurostimulation therapy (LINT) for the lumbar spine (unknown sessions): 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) Low Back Chapter, Hyperstimulation Analgesia.

Decision rationale: MTUS does not address this request. ODG states that Localized intense Neurostimulation 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 Localized intense neurostimulation therapy (LINT) for the lumbar spine (unknown sessions) is not medically necessary due to lack of sufficient evidence to recommend its use as per ODG.