

Case Number:	CM13-0038037		
Date Assigned:	12/18/2013	Date of Injury:	07/19/2013
Decision Date:	04/29/2014	UR Denial Date:	09/24/2013
Priority:	Standard	Application Received:	10/24/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine, and is licensed to practice in California. 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 Physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This patient is 41-year-old female with date of injury of 07/19/2013. Per treating physician's report 09/12/2013, the listed diagnoses are: (1) Cervical spine pain, (2) Cervical spine radiculopathy, (3) Left shoulder impingement syndrome, (4) Lateral epicondylitis, left elbow, (5) Left wrist pain, rule out carpal tunnel syndrome, (6) Left hand contusion, (7) Low back pain, (8) Lumbar spine radiculopathy, (9) Kidney pain, rule out calculus of kidney. The mechanism of injury was that of twisting and falling forward putting her hands out in an attempt to break the fall. Current complaints include neck, left shoulder, left elbow, left wrist and hand, low back, and also pain in her kidneys and blood in her urine. Examination shows some reduction of the cervical range of motion, and also left shoulder for external and internal rotation, pain with palpation.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF COMPOUNDED KETOPROFEN 20% GEL 120GMS: 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) - Treatment in Worker's Comp (TWC) Pain Procedure Summary, regarding topical analgesics

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

Decision rationale: This employee presents with pain in the neck, left shoulder, elbow, wrist, hand, low back. The treating physician has prescribed ketoprofen 20% topical cream. The MTUS Guidelines support use of NSAID topicals for peripheral arthritis and tendonitis. In this employee, although, the treating physician describes elbow and wrist pain, and use of topical NSAID may be appropriate, the treating physician does not discuss this medication specifically and its efficacy. The MTUS Guidelines require documentation of pain and function as related to use of medication when treating chronic pain. Progress reports reviewed from 08/03/2013 through 12/09/2013 do not specifically discuss this topical cream and its effectiveness in terms of pain assessment and functional improvement. None of the reports describe exactly how this medication is used, either whether it is used for neck, low back, or elbow, and wrist symptoms. Recommendation is for denial.

PRESCRIPTION OF SYNAPRYN 10MG/1ML 500ML: 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) - Treatment in Worker's Comp (TWC) Pain Procedure Summary, Criteria for Use of Opioids

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Glucosamine (and Chondroitin Sulfate) Page(s): 50.

Decision rationale: This employee presents with widespread pain involving neck, low back, upper and lower extremity, wrist, and hand. The treating physician has prescribed Synapryn which contains tramadol and glucosamine in an oral suspension form. Glucosamine is indicated for arthritic knee conditions. This employee does not present with arthritis of the knee. The treating physician does not provide documentation of any knee problems. The MTUS guidelines indicate glucosamine is "recommended as an option given its low risk in patients with moderate arthritis pain especially for knee osteoarthritis". Given the lack of diagnosis of knee osteoarthritis, glucosamine is not indicated. Recommendation is for denial.

PRESCRIPTION OF TABRADOL 1MG.ML 250ML: 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) - Treatment in Worker's Comp (TWC) Pain Procedure Summary, regarding muscle relaxants

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Cyclobenzaprine (Flexeril®, Amrix®, Fexmid®, generic available) Page(s): 64.

Decision rationale: The treating physician has prescribed Tabradol which contains cyclobenzaprine, methylsulfonylmethane, and other proprietary ingredients according to the treating physician's report 09/30/2013. The MTUS Guidelines indicate that cyclobenzaprine is recommended for a short course of therapy. They further indicate that this medication is not

recommended to be used for longer than 2 to 3 weeks and is most effective within the first 4 days of treatment. In this case, the treating physician does not indicate that this medication will be used on a short term basis. Given that this employee was still on this medication on 12/09/2013, the employee is prescribed this medication on long term basis. Given the lack of MTUS Guidelines support, recommendation is for denial.

PRESCRIPTION OF DEPRIZINE 15MG/ML 250ML: 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) - Treatment in Worker's Comp (TWC) Pain Procedure Summary, regarding NSAIDs

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section NSAIDs, GI symptoms & cardiovascular risk Page(s): 69.

Decision rationale: The treating physician has prescribed Deprizine which is an oral suspension containing ranitidine and other ingredients. The MTUS Guidelines indicate that for use of PPI (proton pump inhibitor) and other agents, patients' GI risk factors should be assessed when they are concurrently using NSAIDs. In this employee, the treating physician does not provide any discussion regarding this employee's GI risk or assessment. There is no documentation of stomach problems or side effects. It is not known why the employee is being prescribed this particular medication. List of medications do not include NSAIDs. Recommendation is for denial.

PRESCRIPTION OF DICOPANOL 5MG/ML 150ML: 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, Section Antihistamines, Sedating H1-blockers, Anxiolytics, Sedatives and Hypnotics

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Section Insomnia Treatments

Decision rationale: The treating physician has prescribed this employee Dicopanol which contains diphenhydramine for treatment of insomnia. The ODG Guidelines indicate that over-the-counter medications such as sedating antihistamines have been suggested for sleep aids, for example diphenhydramine. The guidelines indicate that tolerance seems to develop within a few days. Next day sedation has been noted as well as impaired psychomotor cognitive function. In this case, the treating physician does not document how this medication is helpful. It is also not known why this employee is prescribed oral solution. Reports do not indicate the employee's inability to swallow pills. Furthermore, the ODG Guidelines indicate that tolerance seems to develop within a few days, and the treating physician does not discuss whether or not tolerance has been developed and more importantly whether or not it has been helpful in managing this employee's sleep and improving the level of function. Given the lack of such discussion, recommendation is for denial.

PRESCRIPTION OF FANATREX 15MG/ML 420ML: 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) - Treatment in Worker's Comp (TWC) Pain Procedure Summary, regarding anti-epilepsy drugs (AEDs)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Anti-epileptic Drugs (AEDs), Gabapentin (Neurontin®), Gabaponeâ€¢, generic available).

Decision rationale: This employee is prescribed Fanatrex which contains gabapentin and other proprietary ingredients. This employee does present with radiating symptoms of the upper and lower extremities, and there may be a component of radicular symptoms or neuropathic pain. The use of gabapentin is appropriate and consistent with MTUS Guidelines. However, it is not known why this treating physician is prescribing an oral suspension of this medication. There are no documentations in the progress report that the employee has any problems that would preclude use of oral pill medications. Furthermore, Fanatrex contains "other proprietary ingredients" that are not disclosed. Without knowing what is contained in these medications, it cannot be considered for authorization. Recommendation is for denial.

CERVICAL AND LEFT UPPER EXTREMITY MRI: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

Decision rationale: This employee presents with neck and left upper extremity pain. The treating physician, according to his report 09/12/2013, has requested MRIs of the cervical spine, left shoulder, left elbow, left wrist, and hand and lumbar spine. For MRI of the C-spine, ACOEM Guidelines require emergence of a red flag; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress on a strengthening program intended to avoid surgery; clarification of the anatomy prior to an invasive procedure. In this employee, there is no emergence of red flag, and the examination does not show any physiologic evidence of neurologic dysfunction, and there is no documentation that there has been failure to progress in the strengthening program intended to avoid surgery. One can still consider MRI of the cervical spine, but this employee is still within the first 3 months or acute/subacute phase of pain. It is still not demonstrated whether or not the conservative care has failed to improve this employee's pain. MRI of the cervical spine would appear premature at this time. For MRI of the upper extremities that includes shoulder, elbow, and wrist, again conservative measures have not been fully shown to have failed in this employee as the patient is still within the first three months of injury. For wrist MRI for example, the ODG Guidelines require acute hand or wrist trauma with suspicion for fractures and in chronic wrist pain suspicion for tumor, Kienbock's disease and ligament injury. In this employee, none of these have been documented. In this

employee, the treating physician documents tenderness to palpation at the carpal tunnel, the dorsum of the wrist and triangular fibrocartilage complex according to his report 09/12/2013. However, this employee is still within the acute phase of the injury, and there is no documentation that conservative measures have failed to improve the employee's condition. There is no evidence that x-rays were obtained to rule out fractures and other abnormalities. MRI of the wrist according to the ODG Guidelines require plain films to be normal or equivocal. Recommendation is for denial.

ELECTROMYOGRAPY OF BILATERAL UPPER EXTREMITY: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 262.

Decision rationale: This employee presents with persistent neck and upper extremity pains including numbness and tingling in the wrists and hands. The treating physician has asked for electromyography of the bilateral upper extremities. The ACOEM Guidelines support EMG/NCV studies of the hand/wrist for hand/wrist symptoms stating "appropriate electrodiagnostic studies may help differentiate between CTS (carpal tunnel syndrome) and other conditions such as cervical radiculopathy." Recommendation is for authorization.

ELECTROMYOGRAPHY OF BILATERAL LOWER EXTREMITY: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: This employee presents with persistent low back pain with radiation down the left lower extremity. The request is for EMG of the bilateral lower extremities. Recommendation is for authorization. The ACOEM Guidelines support EMG including H-reflex test for identifying subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. This employee's symptoms have persisted more than 2 months, and recommendation is for authorization.

NERVE CONDUCTION VELOCITY STUDIES BILATERAL UPPER EXTREMITY: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 262.

Decision rationale: This employee presents with persistent neck and upper extremity pains including numbness and tingling in the wrists and hands. The treating physician has asked for NCV studies of the bilateral upper extremities. The ACOEM Guidelines support EMG/NCV studies of the hand/wrist for hand/wrist symptoms stating "appropriate electrodiagnostic studies may help differentiate between CTS and other conditions such as cervical radiculopathy." Recommendation is for authorization.

NERVE CONDUCTION VELOCITY STUDIES OF BILATERAL LOWER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Section Electrodiagnostic Studies

Decision rationale: This employee presents with low back pain with radiating symptoms down the lower extremity. The request is for NCV studies of the lower extremities. Although the ACOEM Guidelines do not specifically discuss NCV studies for lower extremities, the ODG Guidelines indicate that NCV studies are not recommended. "There is minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy." This employee's left lower extremity symptoms are presumed to be coming from the employee's lumbar spine and nerve conduction studies are not indicated. Recommendation is for denial.

PURCHASE OF TENS UNIT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section TENS Page(s): 114-116.

Decision rationale: This employee presents with persistent neck, low back, upper and lower extremity symptoms. The treating physician has asked for TENS unit for purchase. The MTUS Guidelines do not support a TENS unit unless a 1-month trial of TENS unit has been trialed with pain reduction and functional benefit. Given the treating physician's request for TENS unit purchase without documentation of TENS unit trial for 1 month, recommendation is for denial.

PURCHASE OF HOT/COLD UNIT: Overturned

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

Treatment in Worker's Comp (TWC), Neck and Upper Back Procedure Summary, regarding heat/cold applications

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Section hot/cold treatments (L-spine chapter)

Decision rationale: This employee presents with chronic neck and low back symptoms. The treating physician has asked for purchase of hot/cold units. The ODG Guidelines indicate that hot/cold treatments are "recommended as an option for acute pain. At-home local applications of cold pack in the first few days of acute complaints, thereafter, application of heat packs or cold packs." Given the support from the ODG Guidelines, recommendation is for authorization of hot and cold pack unit to treat this employee's persistent pain.

ULTRASOUND OF LUMBAR AND/OR SACRAL VERTEBRAE (VERTEBRA NDC TRUNK): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Section Ultrasound

Decision rationale: This employee presents with persistent low back and lower extremity pain. The treating physician has asked for ultrasound of the lumbar and sacral vertebrae. The MTUS and ACOEM Guidelines are silent regarding use of ultrasound for lumbar spine. However, the ODG Guidelines indicate that ultrasound is not recommended for neither diagnostic nor therapeutic purposes. They indicate that for uncomplicated low back pain, its use would be experimental at best. For therapeutic use, it is not recommended based on the medical evidence which shows that there is no proven efficacy in the treatment of acute low back symptoms. Given the lack of the guidelines support, recommendation is for denial.

CERVICAL, LEFT UPPER EXTREMITY AND LUMBAR EXTRA CORPOREAL SHOCKWAVE TREATMENT: 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) - Treatment in Worker's Comp (TWC), Low Back Procedure Summary, regarding shock wave therapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Section Shockwave Therapy

Decision rationale: The treating physician has recommended extracorporeal shockwave treatment of the cervical, left upper extremity, and lumbar areas. While the MTUS and ACOEM Guidelines do not discuss this particular treatment, the ODG Guidelines indicate under shockwave therapy for lumbar spine that it is "not recommended." The Guidelines indicate that the available evidence does not support the effectiveness of ultrasound or shockwave for treating low back pain. Given the lack of support for this treatment for the lumbar spine, recommendation is for denial. Review of the ODG Guidelines for shockwave therapy in terms of cervical spine does not yield any discussion. It does not appear that there is any support for shockwave therapy for cervical spine either. Recommendation is for denial.