

<b>Case Number:</b>	CM13-0040603		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	09/30/2011
<b>Decision Date:</b>	03/14/2014	<b>UR Denial Date:</b>	10/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2013

### 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 a 40-year-old female with the date of injury of 09/30/2011. The listed diagnoses per [REDACTED] dated 10/01/2013 are: (1) Right shoulder tendinitis, (2) Anxiety disorder, (3) Mood disorder, (4) Stress, (5) Sleep disorder. According to report dated 10/01/2013 by [REDACTED], the patient presents with continued right shoulder pain radiating down to the arm into the fingers, associated with muscle spasm. The patient rates the pain as 8/10 on a pain scale. The patient also complains of stress, anxiety, insomnia, and depression due to her chronic pain. Physical examination of the right shoulder revealed there is +2 tenderness to palpation at the rotator cuff tendon attachment, sensation to pinprick and light touch is slightly diminished over C5, C6, C7, C8, and T1 dermatomes in the right upper extremity. Motor strength is decreased secondary to pain in the right upper extremity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation (TENS)..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114.

**Decision rationale:** The Physician Reviewer's decision rationale: This patient presents with continued complaints of right shoulder pain, stress, anxiety, insomnia, and depression. Treater requests a TENS unit. Utilization review dated 10/23/2013 modified certification to "1-month rental of TENS." Per MTUS Guidelines page 116, "TENS units have not proven efficacy in treating chronic pain and is not recommended as a primary treatment modality but a 1-month home-based trial may be considered for specific diagnosis of neuropathy, CRPS, spasticity, phantom limb pain, and multiple scoliosis. A 1-month trial period of the TENS unit should be documented with documentation of how the unit was used as well as outcomes in terms of pain relief and function." In this case, the patient has shown some radicular pain over C5 to C8 and T1 dermatomes and decreased strength in the upper extremities. Utilization review modified certification for 30-day trial. When TENS unit is indicated, a 30-day trial is recommended first before going to a home use and only after documentation of functional improvement. Given the patient has not had a 30-day trial, anything beyond that would not be warranted and recommendation is for denial.

**Compounded Ketoprofen 20% in PLO gel 120 grams:** 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 Topical Analgesics Page(s): 111.

**Decision rationale:** This patient presents with continued right shoulder pain, stress, anxiety, insomnia, and depression. Treater is requesting compound Ketoprofen cream for patient's pain. Utilization review dated 10/23/2013 denied request stating "Ketoprofen is not currently FDA approved for topical application." The MTUS guidelines support the use of topical NSAIDs for peripheral joint arthritis or tendinitis. However, this patient does not present with peripheral joint problems such as in the elbow and knees. MTUS specifically states, "There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder." Given the patient's diagnosis of right shoulder tendinitis, recommendation is for denial.

**Compounded Cyclophene 5% in PLO gel 120 grams:** 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.

**Decision rationale:** This patient presents with continued right shoulder pain, stress, anxiety, insomnia, and depression. The treater is requesting compound Cyclophene. The MTUS Guidelines regarding topical analgesics state it is largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. MTUS

Guidelines do not support muscle relaxant, topical cream products for management of pain. Recommendation is for denial.

**Synapryn 10mg/1ml oral suspension 500ml: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 80.

**Decision rationale:** This patient presents with continued right shoulder pain, stress, anxiety, insomnia, and depression. Treater is requesting Synapryn which is a compound drug including tramadol, hydrochloride, and glucosamine. Utilization review dated 10/23/2013 denied request stating "guideline criteria have not been met as there is no documentation of a maintained increase in function or decrease in pain." The MTUS Guidelines page 75 states a small class of synthetic opioids, for example, tramadol exhibits opiates activity and a mechanism of action that inhibits the re uptake of serotonin and norepinephrine. Central analgesic drugs such as tramadol are reported to be effective in managing neuropathic pain. Given the extent of patient's pain 8/10, a synthetic opioid like tramadol may be warranted. However, the treater is requesting Synapryn, a compound drug with tramadol and glucosamine without specifying the reason why both are needed. Glucosamine is indicated for painful arthritis of the knee which this patient does not suffer from. Recommendation is for denial.

**Tabradol 1mg/ml oral suspension 250ml: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64.

**Decision rationale:** This patient presents with continued right shoulder pain, stress, anxiety, insomnia, and depression. The treater requests Tabradol (cyclobenzaprine) 5 mg 2 to 3 times per day. The MTUS Guidelines page 64 states cyclobenzaprine is recommended for short course of therapy limited mixed evidence does not allow for recommendation for chronic use. Cyclobenzaprine is a skeletal muscular relaxant and central nervous system depressant with similar effects to tricyclic antidepressants. Cyclobenzaprine is not recommended for long term use. The treating physician does not indicate that this is for short term management of spasms or acute pain. Recommendation is for denial for the unknown quantity or duration of this medication.

**Deprizine 15mg/ml oral suspension 250 ml: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22, 67-68.

**Decision rationale:** This patient presents with continued right shoulder pain, stress, anxiety, insomnia, and depression. Utilization review dated 10/23/2013 denied request for Deprizine stating lack of discussion regarding any gastric issues in this patient. Deprizine treats and prevents heartburn with acid indigestion. It is also noted to treat stomach ulcers; gastroesophagus reflux disease (GERD). This medicine is a histamine H2-blocker. The MTUS, ACOEM, and ODG Guidelines do not specifically discuss Deprizine. However, MTUS page 69 states under NSAIDS, GI symptoms and cardiovascular risk recommendations are with precautions as indicated below. Clinicians should weigh the indications for NSAIDS against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events:

1. Age is over 65 years.
2. History of peptic ulcer or GI bleeding or perforations.
3. Congruent use of ASA, corticosteroids, and anticoagulant.
4. High-dose/multiple NSAIDs.

Given the patient has been on long term NSAID, as in this case Motrin, recommendation is for approval.

**Dicopanol 5mg/ml oral suspension 150ml:** 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).

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

**Decision rationale:** This patient presents with continued right shoulder pain, stress, anxiety, insomnia, and depression. Treater is requesting Dicopanol. This drug classification is antiemetic, histamine-1, receptor antagonist, an oral formulation for benadryl. The MTUS, ACOEM, and ODG guidelines do not discuss Dicopanol. Treater states that Dicopanol is a "great alternative" as Zolpidem has many side effects. The treater goes on to state this medication is "widely used in many nonprescription sleep aids and cold medications for many years." ODG guidelines has the following regarding anti-Histamine for insomnia: (4) Over-the-counter medications: Sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine). Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. Side effects include urinary retention, blurred vision, orthostatic hypotension, dizziness, palpitations, increased liver enzymes, drowsiness, dizziness, grogginess and tiredness. ODG states that tolerance develops within a few days. It does not appear to be intended for a long-term use. Furthermore, it is not known why the treater is prescribing oral suspension formulation for this drug. There is no documentation regarding the patient's inability to swallow pills. Recommendation is for denial.

**Fanatrex 25mg/ml oral suspension 420ml:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18-19.

**Decision rationale:** This patient presents with continued right shoulder pain, stress, anxiety, insomnia, and depression. Treater requests Fanatrex 25 mg. Utilization review dated 10/23/2013 denied request stating "it is not clear that this patient specifically has a neuropathic pain diagnosis." The MTUS Guidelines has the following regarding gabapentin page 18 to 19. Gabapentin has shown to be effective for treatment of diabetic painful neuropathy and post-therapeutic neuralgia and has been considered a first-line treatment for neuropathic pain. Given this patient has shown some radicular pain over C5 to C8 and T1 dermatomes and decreased strength in the upper extremities, Gabapentin may be warranted at this time. Recommendation is for approval.

**MRI right shoulder, open:**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-207.

**Decision rationale:** This patient presents with continued right shoulder pain, stress, anxiety, insomnia, and depression. Treater requests an MRI of the right shoulder. Utilization review denied request stating "there is no documentation of any red flags, positive orthopedic testing suggestive of internal derangement or any other clear rationale for a shoulder MRI." The MTUS Guidelines do not discuss MRI of the shoulder. ACOEM Guidelines regarding MRI of the shoulder page 207 to 208 states "routine testing and more specialized imaging studies are not recommended during the first month to 6 weeks of activity limitation due to shoulder symptoms except when a red flag noted on history or examination raises suspicion of a serious shoulder condition or referred pain." Review of reports dated 06/20/2013, 07/07/2013, 08/01/2013, and 10/01/2013 show patient complaints of persistent left shoulder pain. The most recent progress report dated 10/01/2013 notes patient's complaints of right shoulder pain radiating down the arms into fingers associated with muscle spasm. Patient rates pain as 8/10 on a pain scale. Given patient's continued complaints lasting over 6 months, an MRI at this juncture may be warranted for further investigation. Recommendation is for approval.

**Chiropractic treatment (frequency/duration not specified):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-59.

**Decision rationale:** This patient presents with continued right shoulder pain, stress, anxiety, insomnia, and depression. Treater requests chiropractic care. Utilization review dated 10/23/2013 denied request stating "there is no documentation to support frozen shoulder or any functional deficit likely to respond to treatment with chiropractic care." For manual therapy manipulation, the MTUS Guidelines page 58 and 59 states, "recommended for chronic pain if caused by musculoskeletal conditions. Manual therapy is widely used in the treatment of musculoskeletal pain. The intended goal of effective 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. Trial of 6 visits over 2 weeks with evidence of objective functional improvement, a total of up to 18 visits over 6-8 weeks, is recommended." Although this patient would benefit from a trial of chiropractic sessions, recommendation cannot be made on an open-ended request for "chiropractic care." Recommendation is for denial.