

<b>Case Number:</b>	CM13-0049124		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	10/20/2006
<b>Decision Date:</b>	04/11/2014	<b>UR Denial Date:</b>	10/10/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/07/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an 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 74-year-old female with date of injury on 10/20/2006. According to the report on 09/20/2013, listed diagnoses are: 1. Cervical spine HNP. 2. Radiculopathy. 3. Left shoulder rotator cuff tear. 4. Status post left shoulder surgery with residual pain. 5. Right shoulder sprain/strain. 6. Lumbar spine herniated nucleus pulposus. 7. Lower extremities radiculitis. 8. Status post surgery. 9. Anxiety, mood and sleep disorder. The patient's presenting symptoms are pain in the neck, burning, radicular symptoms 7/10, status post left shoulder surgery with residual pain radiation down to the arm to the fingers, sharp stabbing low back pain at intensity of 8/10, feelings of anxiety and depression stress. The patient's symptoms persist, but the medications do offer her temporary relief in pain and improve her ability to have restful sleep, no problems with medications, and pain is also alleviated by activity restrictions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Amitriptyline/Dextromethorphan/Tramadol Cream (Retrospective/Prospective): 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.

**Decision rationale:** This employee presents with widespread pain including the neck, low back, and shoulders. The treating physician has prescribed topical combination cream including Elavil/dextromethorphan/tramadol. The MTUS Guidelines regarding topical creams discuss that when one of the components is not recommended, the entire compound is not recommended. In this case, there is no support for any of these compounds including Elavil, dextromethorphan, and tramadol as a topical formulation. Recommendation is for denial.

**Capsaicin/Diclo/Menthol/Camphor Cream (Retrospective/Prospective): 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.

**Decision rationale:** This employee presents with widespread pain in the neck and the lower leg, upper extremities, low back, and lower extremities. The treating physician has prescribed a topical combination cream that includes capsaicin/diclofenac/menthol/camphor cream. The MTUS Guidelines indicate on page 111 regarding topical analgesics that any compounded product that contains at least one drug that is not recommended is not recommended. In this case, diclofenac is a topical nonsteroidal antiinflammatory agent. For nonsteroidal antiinflammatory agent topical cream, the MTUS Guidelines indicate that it is only indicated for peripheral joint osteoarthritis or tendinitis. The list of diagnoses on this employee does not include peripheral joint osteoarthritis or tendinitis. Most of the symptoms and diagnoses are axial in nature including cervical spine, lumbar spine, and shoulders with diffuse radiating symptoms into the upper and lower extremities. There is no indication for the use of a topical NSAID. Recommendation is for denial.

**Diclofenac Cream (Retrospective/Prospective): 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.

**Decision rationale:** This employee presents with chronic neck and low back, upper and lower extremity pains including shoulders. The treating physician has prescribed diclofenac topical cream. However, the MTUS Guidelines allow topical NSAIDs for "osteoarthritis and tendinitis in particular that of the knee and elbow or other joints that are amenable to topical treatment". It is also recommended for short-term use only. The MTUS Guidelines specifically state "There is little evidence utilized topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder". It is also not recommended for neuropathic pain. This employee does not present with peripheral joint tendinitis or osteoarthritis. The employee's problems are primarily of that of

neck, low back, shoulders, with radiating radicular symptoms into upper and lower extremities. Recommendation is for denial.

**Synapryn (Retrospective/Prospective): Upheld**

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

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

**Decision rationale:** This employee presents with widespread pain involving the neck, low back, upper and lower extremities as well as bilateral shoulders. The treating physician has prescribed medication called Synapryn. Synapryn is a compounded oral suspension that includes tramadol, hydrochloride 10 mg/mL in oral suspension with glucosamine. Tramadol is a synthetic opiate used for chronic pain. Glucosamine is recommended as an option given its low risk in patients with moderate arthritis pain, especially for knee osteoarthritis, according to the MTUS Guidelines page 50. In this employee, while there is a long list of diagnoses including cervical spine HNP, radiculopathy, shoulder rotator cuff tear with surgery, lumbar herniated disk with radiculitis, status post surgery, but there is not a diagnosis of arthritis of the knee. Glucosamine sulfate does not appear to be indicated in this employee. Given the employee's chronic pain, while use of tramadol may be indicated, Synapryn contains combination of tramadol and glucosamine. Since glucosamine is not indicated, recommendation is for denial.

**Tabradol (Retrospective/Prospective): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain)..

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

**Decision rationale:** This employee presents with widespread pain of the neck, low back, upper and lower extremities, and bilateral shoulders. The treating physician is prescribing Tabradol which contains cyclobenzaprine in oral suspension with MSM. The MTUS Guidelines page 64 under cyclobenzaprine states that it is recommended for a short course of therapy with a number needed to treat at 2 weeks for symptom improvement. It further states that the greatest effect appears to be in the first 4 days of the treatment. In this employee, there is no indication that this medication is used for short-term use only. None of the reports reviewed from 06/13/2013 to 09/20/2013 shows that this medication is to be used for short term only. Therefore, recommendation is for denial.

**Deprizine (Retrospective/Prospective): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk..

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

**Decision rationale:** This employee presents with widespread pain involving the neck, upper extremities, bilateral shoulders, low back, and lower extremities. The treating physician has prescribed Deprizine which is a ranitidine to presumably counter potential gastric side effects from the use of NSAID. The treating physician's report 08/26/2013 describes that this medication is prescribed for prophylactic treatment for NSAIDS-induced GI ulcers/bleeds. However, none of the reports reviewed show that this employee is actually experiencing GI side effects. Each of the treating physician report has the following statement; "The patient states that the symptoms persist, but the medications do offer temporary relief of pain and improve ability to have restful sleep. The employee denies any problems with the medications. The pain is also alleviated by activity restrictions". It would appear that the employee is not having any problems with the medication. Furthermore, there is no indication that the employee is actually taking any NSAIDS and it is not clear why the employee is being prescribed ranitidine. The MTUS Guidelines require GI risk assessment for prophylactic use of PPI. GI risk assessment include age greater than 65; history of peptic ulcer; GI bleeding or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants, high dose/multiple NSAIDS, et cetera. In this case, the treating physician does not provide any risk assessment. There is no documentation that the employee has any GI events from use of NSAIDS or SSRIs. Recommendation is for denial.

**Dicopanol (Retrospective/Prospective):** 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), Insomnia Treatments.

**Decision rationale:** This employee presents with chronic widespread pain in the neck, low back, upper and lower extremities, and bilateral shoulder pains. The treating physician has prescribed Dicopanol which is a diphenhydramine hydrochloride oral suspension. The treating physician's report, 08/21/2013, has a generic recommendation and discussion regarding Dicopanol stating that diphenhydramine's sedative properties make it a great alternative and widely use in many non-prescription sleep aides and cold medication for many years. While MTUS and ACOEM Guidelines do not discuss diphenhydramine, the ODG Guidelines state "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 functions." The MTUS Guidelines page 60 when discussing medications for chronic pain indicagte that efficacy needs to be demonstrated as it relates with the use of the medication. In this employee, none of the reports specifically discuss how diphenhydramine has been helping this employee. There was no discussion as to why oral suspension is used when there are oral pills that can be easily consumed. Furthermore, the ODG

Guidelines indicate that tolerance has developed within a few days for use of diphenhydramine. Recommendation is for denial.

**Fanatrex (Retrospective/Prospective): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy Drugs (AEDs).

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

**Decision rationale:** This employee presents with chronic neck, low back, upper and lower extremities radiating symptoms. The treating physician has prescribed Fanatrex which is an oral suspension for gabapentin. While this employee has radicular symptoms in the upper and lower extremities, a trial of gabapentin may be reasonable. The MTUS Guidelines recommends trial of gabapentin over 3 to 8 weeks for titration, then 1 to 2 weeks at maximal tolerated dosage. It further states "the patient should be asked at each visit as to whether there has been a change in pain or function." In this employee, none of the reports reviewed from 06/13/2013 to 09/20/2013 describe whether or not gabapentin has been effective in managing this employee's radicular symptoms. The treating physician only prescribes them but does not provide any monitoring as to the efficacy of the medication. Reports only provide a generic statement stating that the symptoms persist but the medications offer temporary relief. None of the reports go into any details regarding the use of gabapentin and its effectiveness. Recommendation is for denial.

**Periodic UA toxicology evaluation: Upheld**

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

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

**Decision rationale:** This employee presents with widespread pain of the upper and lower extremities, neck, low back, and bilateral shoulders. There is a request for routine urine toxicology. However, the reason for urine toxicology is for monitoring chronic opioid use. In this employee, listed medications do not include any of the opiates and it is not clear why urine toxicology is being requested. The MTUS Guidelines regarding urine toxicology clearly indicate that this is used to monitor chronic opiate use and also its potential abuse. Given that in this employee an opiate is not being used or closely monitored, recommendation is for denial.

**Physical Therapy twice a week for four weeks for the left shoulder: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** This employee presents with chronic left shoulder pain as well as neck, low back radiating symptoms to upper and lower extremities. The treating physician is requesting physical therapy 2 times a week for 4 weeks to address the left shoulder pain. The treating physician's report from 07/19/2013 has a check mark next to therapies and left shoulder physical therapy as well as acupuncture and shockwave therapy. The treating physician does not describe how the employee has responded to physical therapy in the past and what the reasons are for prescription of additional therapy at this juncture. Review of the reports showed that this employee is status post left shoulder surgery from January 2013. Included in the reports are some handwritten physical therapy visitations from April 2013. It appears that the employee had some 10 sessions of physical therapy around April 2013. In regard to physical therapy, MTUS Guidelines allow 9 to 10 visitations for myositis/myalgia type of symptoms which appears to be what this employee is suffering from in terms of the left shoulder. The employee is outside of postoperative physical therapy, and therefore, 9 to 10 sessions of therapy sessions are reasonable. However, in this employee, the employee already received 10 sessions of physical therapy back in April 2013. The treating physician does not describe whether or not therapy has been helpful in the past and what is to be accomplished with additional physical therapy. The MTUS Guidelines page 8 require close physician monitoring of the employee's progress and appropriate recommendations for treatments. In this case, the treating physician does not explain why additional therapy is required at this juncture and with what goals and what purposes. Given that the employee has already completed 10 sessions of therapy back in April 2013, additional physical therapy does not appear to be supported by MTUS Guidelines which allows 9 to 10 visits for myalgia/myositis type of problems. Recommendation is for denial.

**Extracorporeal shockwave therapy once a week for six weeks for the cervical/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)-- Treatment in Workers Comp (TWC) Low Back Procedure Summary; and Blue Cross Blue Shield of Alabama: Extracorporeal Shock Wave Treatment for Plantar Fasciitis and Other Musculoskeletal Conditions.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Section Shoulder, Elbow and Heel Chapters; shockwave therapy

**Decision rationale:** This employee presents with chronic neck and low back symptoms with radiating symptoms in the upper and lower extremities. The treating physician has asked for shockwave therapy to address the cervical and lumbar spine. However, the MTUS and ACOEM Guidelines do not specifically discuss shockwave therapies for cervical and lumbar spine. When shockwave therapy is discussed, it is in reference to either elbow, shoulder, or heel problems. For instance, when reading criteria for extracorporeal shockwave therapy in ODG Guidelines, it is listed under shoulder, elbow, and heel chapters but not in cervical or lumbar spine. There is lack of evidence that these shockwave therapy treatments are efficacious for neck and low back

symptoms. There is no indication that these treatments are supported for chronic neck and low back symptoms. Recommendation is for denial.

**Extracorporeal shockwave therapy once a week for three weeks for the bilateral shoulders:**  
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 Workers Comp (TWC) Low Back Procedure Summary; and Blue Cross Blue Shield of Alabama: Extracorporeal Shock Wave Treatment for Plantar Fasciitis and Other Musculoskeletal Conditions.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Section Shoulder, Elbow and Heel Chapters; shockwave therapy

**Decision rationale:** This employee presents with chronic bilateral shoulder pains. The employee is status post left shoulder surgery from January 2013. The treating physician has asked for bilateral shoulder extracorporeal shockwave therapy. The MTUS Guidelines do not specifically discuss shockwave therapy. However, the ODG Guidelines indicate that shockwave therapy is indicated for patients suffering from shoulder pain with calcific tendinitis. In this employee, MR arthrogram did not reveal calcific tendinitis but full thickness tear of the supraspinatus tendon. Description of x-rays reviewed from November 2012, the treating physician's reports, with no description of calcific tendinitis. Given the lack of the diagnosis of calcific tendinitis of the shoulder, shockwave therapy is not indicated. Recommendation is for denial.