

Case Number:	CM14-0163850		
Date Assigned:	10/09/2014	Date of Injury:	12/15/1999
Decision Date:	11/28/2014	UR Denial Date:	09/05/2014
Priority:	Standard	Application Received:	10/06/2014

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. The expert reviewer is Board Certified in Physical Medicine and 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 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/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:

The patient is a 62 years old male with an injury date on 12/15/1999. Based on the 07/30/2014 progress report provided by [REDACTED], the diagnoses are: 1. Cervical spine pain 2. Cervical spine sprain/strain 3. R/o cervical disc displacement HNP 4. Cervical spine radiculopathy 5. Bilateral shoulder sprain/strain 6. R/o bilateral shoulder internal derangement 7. Low back pain 8. R/o lumbar disc displacement HNP 9. Radiculitis, lower extremity According to this report, the patient complains of burning, radicular neck and low back pain with muscle spasms that are constant, moderate to severe. Pain is rate at a 7/10. Pain is aggravated by looking up/down, move head side to side with repetitive motion, prolonged sitting, standing, walking, bending, arising from a sitting position, stooping, and ascending/descending stairs. Numbness and tingling of the bilateral upper and lower extremities are noted. The patient also complains of burning shoulders pain radiating down the arm to the fingers, associated with muscle spasms. Pain is rated at a 7/10. Medications do offer the patient "temporary relief of pain and improve his ability to have a restful sleep." Physical exam reveals tenderness at the cervical/ lumbar paraspinal muscles, lumbrosacral junction, sciatic notch, sternocleidomastoid muscles, bilateral rotator cuff muscles, AC joint, subacromial space, distal radio ulnar joint and at the dorsum of the right wrist. Sensation to pinprick and light touch is slight diminished over the C5, C6, C7, C8, T1, L4, L5, and S1 dermatomes, bilaterally. Motor strength is a 4/5 in all represented muscles groups in the bilateral upper and lower extremities. There were no other significant findings noted on this report. The utilization review denied the request on 09/05/2014. [REDACTED] is the requesting provider, and he provided treatment reports from 05/12/2014 to 08/04/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription of Synapryn 10mg/1ml 500ml #1: 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 Medications for chronic pain, Criteria For Use Of Opioids Page(s): 60-61, 76-78, 88-89.

Decision rationale: According to the 07/30/2014 report by [REDACTED] this patient presents with burning, radicular neck and low back pain with muscle spasms that are constant, moderate to severe. The treater is requesting synapryn 10mg/1ml 500ml #1. Synapryn (Tramadol) was first mentioned in the 05/12/14 report; it is unknown exactly when the patient initially started taking this medication. The urine drug on 05/12/2014 was consistence with medications prescription. For chronic opiate use, MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and aberrant behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Review of report shows documentation of pain assessment using a numerical scale describing the patient's pain and some ADL's are discussed. However, no outcome measures are provided; No aberrant drug seeking behavior is discussed, and no discussion regarding side effects. Given the lack of sufficient documentation demonstrating efficacy from chronic opiate use, the patient should be slowly weaned as outlined in MTUS Guidelines. Recommendation is not medically necessary.

3 Shockwave therapy sessions for the bilateral shoulders and right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

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 under shockwave therapy

Decision rationale: According to the 07/30/2014 report by [REDACTED] this patient presents with burning, radicular neck and low back pain with muscle spasms that are constant, moderate to severe. The treater is requesting shockwave therapy for the bilateral shoulder and wrist. MTUS does not discuss ESWT for the shoulder, however ODG guidelines does discuss ESWT, "Extracorporeal shock wave therapy (ESWT) has been suggested to be an effective treatment option for treating calcific tendinitis of the shoulder before surgery, but after conservative treatments, including physical therapy, iontophoresis, deep friction, local or systemic application of noninflammatory drugs, needle irrigation-aspiration of calcium deposit, and subacromial bursal steroid injection." ODG furthermore states, contraindicated for patients

who had previous surgery for the condition. In this case, there is no documentation of "calcific tendinitis" of the shoulder. No documentations of conservative treatments, including physical therapy, iontophoresis or deep friction. The requested shockwave therapy for the bilateral shoulder and wrist are not in accordance with ODG guidelines. Recommendation is not medically necessary.

6 Shockwave therapy sessions for the cervical spine and 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, Low Back-Lumbar & Thoracic (Acute & Chronic)

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 under shockwave therapy

Decision rationale: According to the 07/30/2014 report by [REDACTED] this patient presents with burning, radicular neck and low back pain with muscle spasms that are constant, moderate to severe. The treater is requesting shockwave therapy sessions for the cervical spine and lumbar spine. Regarding ESWT, MTUS and ODG does not discuss ESWT for the cervical spine, however ODG guidelines does discuss ESWT for the lumbar spine. ODG states "Not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating LBP. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. (Seco, 2011)." Recommendation is not medically necessary.

6 Localized intense neurostimulation therapy (LINT) sessions 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, Low Back-Lumbar & Thoracic (Acute & Chronic)Hyperstimulation analgesia

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 under Localized High Intense Neurostimulation

Decision rationale: According to the 07/30/2014 report by [REDACTED] this patient presents with burning, radicular neck and low back pain with muscle spasms that are constant, moderate to severe. The treater is requesting Localized Intense Neurostimulation Therapy for the Lumbar Spine #6. Regarding Hyperstimulation analgesia, ODG guidelines states "Not recommended until there are higher quality studies." In this case, the requested Neurostimulation Therapy is not supported by the guidelines, recommendation is not medically necessary.

Unknown prescription of terocin patches: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesic Page(s): 111-112.

Decision rationale: According to the 07/30/2014 report by [REDACTED] this patient presents with burning, radicular neck and low back pain with muscle spasms that are constant, moderate to severe. The treater is requesting Terocin patches (unkown prescription). Terocin patches are a dermal patch with 4% lidocaine, and 4% menthol. The MTUS guidelines state that Lidoderm patches may be recommended for neuropathic pain when trials of antidepressants and anti-convulsants have failed. Review of the reports indicate that the patient has numbness and tingling of the upper and lower extremities indicated for neuropathic pain. However, there is no documentation of the effects of this medication as required per page 60 of MTUS. Furthermore, Lidoderm patches are not recommended for axial back pain but peripheral, localized neuropathic pain. Recommendation is not medically necessary.

1 Prescription of Ketoprofen 20% cream 165gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesicsNSAIDS, non-steroidal anti-inflammatory drug.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesic Page(s): 111-113.

Decision rationale: According to the 07/30/2014 report by [REDACTED] this patient presents with burning, radicular neck and low back pain with muscle spasms that are constant, moderate to severe. The treater is requesting Ketoprofen 20% cream 165 gm. The MTUS Guidelines page 111 has the following regarding topical creams, "topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety."Furthermore, MTUS specifically states "Non FDA-approved agents: Ketoprofen: This agent is not currently FDA approved for a topical application." Recommendation is not medically necessary.

1 Prescription of Cyclobenzaprine 5% cream 100gm #1: 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 analgesic Page(s): 111-113.

Decision rationale: According to the 07/30/2014 report by [REDACTED] this patient presents with burning, radicular neck and low back pain with muscle spasms that are constant, moderate to severe. The treater is requesting Cyclobenzaprine 5% cream 100gm #1. Regarding Cyclobenzaprine topical, MTUS states Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product. Recommendation is not medically necessary.

1 Prescription of Dicopanol 5mg/ml 150ml #1: 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 analgesic Page(s): 111-113.

Decision rationale: According to the 07/30/2014 report by [REDACTED] this patient presents with burning, radicular neck and low back pain with muscle spasms that are constant, moderate to severe. The treater is requesting Decopanol 5mg/mL #. Dicopanol is diphenhydramine 5mg/ml in an oral suspension with other proprietary ingredients. MTUS in general for compounded medications, page 111 states "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." The "other proprietary ingredients" are not disclosed. Since components of "other proprietary ingredients" are unknown, they cannot be compared against MTUS criteria, and therefore cannot be confirmed to be in accordance with MTUS. Dicopanol is not medically necessary.

1 Prescription of Deprizine 15mg/ml oral suspension 250ml #1: 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 NSAIDs, GI symptoms & cardiovascular risk Page(s): 69.

Decision rationale: According to the 07/30/2014 report by [REDACTED] this patient presents with burning, radicular neck and low back pain with muscle spasms that are constant, moderate to severe. The treater is requesting Deprizine 15mg/mL oral suspension 250mL #1. The MTUS Guidelines state Deprizine is recommended for patients at risk for gastrointestinal events if used prophylactically for concurrent NSAIDs. MTUS requires proper GI assessment such as the age, concurrent use of anticoagulants, ASA, history of PUD, gastritis, etc. Review of reports show no mentions of Deprizine and it is unknown exactly when the patient initially started taking this medication. Medical records do not show that the patient has gastrointestinal side effects with medication use. There is no discussion regarding GI assessment as required by MTUS. MTUS does not recommend routine use of GI prophylaxis without documentation of risk. In addition, the treater does not mention symptoms of gastritis, reflux or other condition that would require a PPI. There were no discussions as of why Deprizine cannot be taken in a tablet form. Recommendation is not medically necessary.

1 Prescription of Fanatrex 25mg/ml 420ml #1: 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 Gabapentin (Neurontin) Page(s): 18-19, 49.

Decision rationale: According to the 07/30/2014 report by [REDACTED] this patient presents with burning, radicular neck and low back pain with muscle spasms that are constant, moderate to severe. The treater is requesting Fanatrex 25mg/mL 420mL #1. Regarding Anti-epileptic (AKA anti-convulsants) drugs for pain, MTUS Guidelines recommend for "treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain." Review of reports show no mentions of Fanatrex and it is unknown exactly when the patient initially started taking this medication. Review of reports indicate that the patient has neuropathic pain. The ODG guidelines support the use of anti-convulsants for neuropathic pain. However, the treater does not mention that this medication is working. There is no discussion regarding the efficacy of the medication. Without documentation that this medication is working and helping with pain and function, continued use of the medication would not be indicated, per MTUS. Recommendation is not medically necessary.

1 Prescription of Tabradol 1mg/ml 250ml #1: 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 analgesic Page(s): 111-113.

Decision rationale: According to the 07/30/2014 report by [REDACTED] this patient presents with burning, radicular neck and low back pain with muscle spasms that are constant, moderate to severe. The treater is requesting Tabradol 1mg/mL 250mL #1. Tabradol is reported to contain Methsulfonylethane (MSM) and Cyclobenzaprine. Under topical analgesics, MTUS states that if one of the compounded product is not recommended then the entire compound is not recommended. MSM is not FDA approved for medical treatment of any condition. Regarding Cyclobenzaprine topical, MTUS states Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product. Recommendation is not medically necessary.

1 Urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine drug testing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine drug screen Page(s): 43.

Decision rationale: According to the 07/30/2014 report by [REDACTED] this patient presents with burning, radicular neck and low back pain with muscle spasms that are constant, moderate to severe. The treater is requesting 1 urine drug screen. The utilization review denial letter states "records do not reveals that the patient has exhibited any cautionary red flags of addiction or potential opioid abuse." Regarding UDS's, MTUS Guidelines do not specifically address how

frequent UDS should be obtained for various risks of opiate users, ODG Guidelines provide clearer recommendation. It recommends once yearly urine screen following initial screening with the first 6 months for management of chronic opiate use in low risk patient. In this case, the available medical records indicate the patient is currently on Synapryn (a narcotic-like pain reliever). Review of the reports show a recent UDS was done on 06/25/2014. There were no discussions regarding the patient adverse behavior with opiates use. The treater does not explain why another UDS is needed. There is no discussion regarding this patient' opiate use risk. Recommendation is not medically necessary.