

<b>Case Number:</b>	CM14-0180670		
<b>Date Assigned:</b>	11/05/2014	<b>Date of Injury:</b>	11/03/2005
<b>Decision Date:</b>	12/12/2014	<b>UR Denial Date:</b>	09/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2014

### 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 Family Medicine 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:

This 65-year old home care nurse reported an injury to her left shoulder after lifting a patient on 11/3/05. Other injuries have since been added, apparently attributed to compensation for the left shoulder injury or to cumulative trauma from her job. Her medical history is notable for obesity, diabetes and hypertension. She has not worked since January 2006. Although she is able to drive, she has not driven since her injury. According to her primary treater, her current diagnoses include: Discogenic lumbar condition with radiculopathy and facet arthrosis; discogenic cervical condition with multilevel disc disease and nerve entrapment; bilateral shoulder impingement; bilateral carpal tunnel syndrome; chronic pain syndrome; and depression. Treatment has included medications with long term use of opioids and muscle relaxants, surgery on both shoulders, two left wrist surgeries and one right wrist surgery, an injection of the left shoulder and the right wrist, extensive physical therapy, and psychological counseling. Her most recent surgery (of the right shoulder) was performed on 4/17/14. The record contains a 6/21/14 a review by a psychologist of a battery of questionnaires and tests completed by the patient. The psychologist noted concern for symptom magnification, somatoform disorder, and possibly "seeking the disabled role". The most recent progress note from the primary treater is dated 9/18/14. It documents continued stiffness of the right shoulder. The patient has been living on disability and is eager to settle her claim. The patient "has access to" a back brace, a collar with gel, a neck pillow, a TENS unit with hot and cold wrap, and to soft and rigid braces. Physical exam findings include BP of 160/82, locking of the right middle finger, positive Tinel's at the right wrist, mild impingement at the right shoulder, and limited right shoulder range of motion. Right wrist fluoroscopy was performed at this visit despite lack of authorization. It revealed "ulnar negative/neutral variance with thumb sparing along the CMC joint". Diagnoses are as above. Treatment plan includes a retrospective request for authorization for steroid injection of

the right middle finger (also performed 9/8/14), a prospective request for a right carpal tunnel injection, a prospective request for fluoroscopy for the left wrist and neck, continued physical therapy (beyond the 12 post-op visits already performed), provision of a neck traction unit with air bladder, a request for nerve studies of upper and lower extremities, provision of or prescription for Norco #120, Flexeril 7.5 mg #60, Nalfon 400 mg #60, tramadol ER 150 mg #30, Neurontin 600 mg #90, and Protonix 20 mg #60. A request for authorization dated 9/8/14 was also submitted, which apparently also included a request for a cervical collar, although it is not listed on the RFA form in my records.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Retrospective cervical traction device (DOS: 9/8/14): 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:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173, 181, Chronic Pain Treatment Guidelines Page(s): 10.

**Decision rationale:** The MTUS Chronic Pain Guidelines do not specifically address cervical traction. However, per page 10 of the Guidelines, when a patient is diagnosed with chronic pain and the treatment for the condition is covered in the clinical topics sections but is not addressed in the chronic pain medical treatment guidelines, the clinical topics section applies to that treatment. Per the clinical topics upper back and neck section, page 181, cervical traction is not recommended. Per page 173, traction is one of many passive modalities not supported by good medical evidence which may be used on a trial basis. Emphasis should be on functional restoration and return to activities of daily normal living. The clinical records in this case do not support the provision of a cervical traction device to this patient. The provider has not documented any rationale for its use at all, let alone a rationale that would supersede the ACOEM recommendation against the use of cervical traction. It appears that its use may further reinforce the patient's passive role and impede progress toward functional restoration. Based on the MTUS guidelines above and on the clinical documentation provided for my review, a cervical traction device is not medically necessary because the provider has not documented any justification for its use, because it is not recommended by ACOEM, and because its use may actually impede the patient's return to active function.

#### **Retrospective cervical collar (DOS: 9/8/14): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174-175, 181, Chronic Pain Treatment Guidelines Page(s): 10.

**Decision rationale:** The MTUS Chronic Pain Guidelines do not specifically address cervical collars. However, per page 10 of the Guidelines, when a patient is diagnosed with chronic pain and the treatment for the condition is covered in the clinical topics sections but is not addressed in the chronic pain medical treatment guidelines, the clinical topics section applies to that treatment. Per the clinical topics neck and upper back chapter, page 175, cervical collars have not been shown to have any lasting benefit; except for comfort in the first few days of the clinical course in severe cases. In fact, weakness may result from prolonged use and will contribute to debilitation. Immobilization using collars and prolonged periods of rest are generally less effective than having patients maintain their usual "preinjury" activities. Per page 181, use of a cervical collar is not recommended for more than 1-2 days. The clinical record in this case does not support the provision of a surgical collar to this patient. The provider has not documented any reason for the use of a collar, and in particular has not documented a rationale that would override concerns about prolonged use of a collar raised in the guideline quoted above. Again, this is a form of passive treatment that reinforces the patient in staying in a passive role and in not participating actively in her recovery. Based on the MTUS citations above and on the clinical documentation provided for my review, a cervical collar is not medically necessary, because the provider has not documented any compelling reason for its use, because prolonged use of a cervical collar is not recommended by ACOEM, and because its use may be contributing to continuation of the patient's passive role in her recovery and to her overall disability.

**Retrospective Tramadol 150mg, Qty 30 (DOS: 9/8/14): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (Criteria for Use of Opioids, Ongoing Management, When to Discontinue Opioids, Indications and L. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: UptoDate, an online evidence-based review service for clinicians ([www.uptodate.com](http://www.uptodate.com)), Tramadol: Drug Information

**Decision rationale:** Tramadol 150 mg is the long-acting form of tramadol, which is an opioid analgesic. Per the MTUS recommendations cited above, medications should be trialed one at a time while other treatments are held constant, with careful assessment of function, and there should be functional improvement with each medication in order to continue it. If opioids are used, it is recommended that goals for pain and function be set and monitored. Opioids should be discontinued if there is no improvement in function. There is no good evidence that opioids are effective for radicular pain. If long-term use of opioids occurs, there is a need for ongoing pain and function assessments, as well as assessments for side effects, of concurrent other treatments, and of concurrent psychological issues. Per the UptoDate reference cited above, tramadol increases the risk of seizures even at recommended doses in patients who have not previously had seizures. This risk is increased in patients on other opioids or cyclobenzaprine. The clinical findings in this case do support the prescription of tramadol to this patient. There is no documentation that tramadol was introduced individually, with ongoing careful assessment of function. There is no documentation of evaluation of whether or not the patient's pain is nociceptive or neuropathic. The diagnosis of radiculopathy and the prescription for Neurontin

make it appear that the patient's pain is neuropathic. Neuropathic pain does not necessarily respond well to opioids. No assessment was made of whether or not opioid use was likely to be helpful in this patient, or of her potential for abuse. No specific functional goals were set or followed. It appears likely that the combined sedative effects of the patient's multiple medications, including tramadol, may be contributing to the patient's inability to recover. In addition, this patient is also taking both Norco (another opioid) and cyclobenzaprine (Flexeril). This combination puts her at increased risk for seizures. Based on the evidence-based guidelines cited above, and the clinical documentation provided for my review, tramadol ER #30 is not medically necessary for this patient. Tramadol is not medically necessary because of the lack of appropriate documentation of the patient's status prior to beginning it, because of the failure to set and monitor functional goals, because it is likely that tramadol use is actually contributing to the patient's disability, and because its use in combination with Norco and Flexeril puts her at increased risk for seizures.

**Retrospective Pantoprazole (Protonix) 20mg, Qty: 60 (DOS: 9/8/14): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: UptoDate, an evidence-based online review service for clinicians, ([www.uptodate.com](http://www.uptodate.com)), Pantoprazole: drug information.

**Decision rationale:** Pantoprazole is a proton pump inhibitor (PPI); the first guideline cited above states that clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. They should determine if the patient is at risk for GI events. Risk factors include age over 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of aspirin, corticosteroids, or an anticoagulant; or high-dose or multiple NSAIDs, or an NSAID combined with aspirin. Patients with no GI risk factors and no cardiovascular disease may be prescribed a non-selective NSAID. Those at intermediate risk for GI disease should receive a non-selective NSAID plus a proton pump inhibitor (PPI) or misoprostol; or a Cox-2 selective NSAID. Patients at high GI risk should receive a Cox-2 selective NSAID and a PPI if an NSAID is absolutely necessary. This reference notes that long-term PPI use has been shown to increase the risk of hip fracture. The UptoDate reference cited above lists the indications for pantoprazole as peptic ulcer disease, helicobacter pylori eradication, pathological hypersecretory conditions (such as Zollinger-Ellison syndrome), symptomatic GERD and erosive esophagitis associated with GERD, NSAID-induced ulcer prophylaxis, and stress ulcer prophylaxis in ICU patients. The last two indications are off label in the US. Risks of long-term (usually over one year) use include atrophic gastritis, increased incidence of gastric carcinoid tumors, clostridium difficile-associated diarrhea, increased incidence of osteoporosis-related fractures of the hip, spine, or wrist; hypomagnesaemia and Vitamin B12 deficiency. The clinical records do not support the ongoing use of pantoprazole in this case. It is impossible to guess from the available clinical records why pantoprazole is being prescribed for this patient. There is no documentation of his risk for GI events. There is no documentation of any condition likely to require a PPI prescription or of any symptoms suggestive of such a condition. It does appear likely that the

patient has been taking pantoprazole for at least a year, which would put her at risk for the side effects listed above, many of which could be life threatening. Based on the evidence-based references cited above and the clinical information made available to me, pantoprazole 20 mg #60 is not medically necessary because there is no documentation of any benefit to the patient that is likely to outweigh its risks.

**Retrospective Cyclobenzaprine (Flexeril) 7.5mg, Qty: 60 (DOS: 9/8/14): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, Muscle relaxants Page(s): 60; 63-66. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: UptoDate, an online evidence-based review service for clinicians ([www.uptodate.com](http://www.uptodate.com)), Tramadol: Drug Information

**Decision rationale:** Cyclobenzaprine 7.5 mg is the long-acting form of cyclobenzaprine, which is usually referred to by its brand name, Fexmid. Per the first reference cited above, medications should be trialed one at a time while other treatments are held constant, with careful assessment of function, and there should be functional improvement with each medication in order to continue it. Per the second reference, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In most low back pain patients, they show no benefit. There is no additional benefit if they are used in combination with NSAIDs. Efficacy appears to diminish over time. Cyclobenzaprine is only recommended for a short course of therapy, as there is no evidence to support its long-term use. Its greatest effect appears to occur within the first four days of treatment. Side effects include drowsiness, urinary retention, dry mouth and headaches. Its use should be avoided in patients with arrhythmias, heart block, heart failure and recent myocardial infarction. Per the UptoDate reference cited above, tramadol increases the risk of seizures even at recommended doses in patients who have not previously had seizures. This risk is increased in patients on other opioids or cyclobenzaprine. The clinical documentation in this case does not support the continued use of Fexmid. This patient has been on muscle relaxants for years without improvement in function. The provision of a new, long acting, sedating muscle relaxant is unlikely to result in functional recovery and in fact is likely to inhibit functional recovery via increased sedation. Fexmid is being started in conjunction with Nalfon, which means that it would be impossible to determine which medication is producing any side effect or beneficial effect that occurs. A two-month course of Fexmid is being requested, which already exceeds the short-term use recommended for this medication. As already discussed, this patient is taking tramadol, which decreases the seizure threshold. The possibility of seizure increases with the concurrent use of Fexmid and Norco. Based on the evidence-based citations above and on the clinical records provided for my review, cyclobenzaprine 7.5 mg #60 is not medically necessary in this case because there is no evidence to support its long-term use, because its use is more likely to inhibit functional recovery than to promote it, because it is being started in conjunction with another medication, and because it increases the possibility that the patient may have a seizure when it is combined with either Norco or tramadol.

**Retrospective Nalfon (Fenoprofen) 400mg, Qty: 60 (DOS: 9/8/14): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, hypertensi.

**Decision rationale:** Nalfon is brand-name fenoprofen, which is an NSAID. Per the first reference cited above, medications should be trialed one at a time while other treatments are held constant, with careful assessment of function, and there should be functional improvement with each medication in order to continue it. The NSAID references state that NSAIDs are recommended at the lowest dose for the shortest period possible for patients with moderate to severe pain due to osteoarthritis. There is no evidence to recommend one drug over another in terms of efficacy or pain relief. Cardiovascular risk occurs with all NSAIDs, and there is no evidence of long-term effectiveness for pain or function. NSAIDs are recommended as an option for short-term symptomatic relief of chronic low back pain. There is inconsistent evidence to support their use for neuropathic pain. All NSAIDs have the potential to raise blood pressure in susceptible patients. The greatest risk appears to occur in patients taking ACE inhibitors, ARBs, beta-blockers or diuretics. The clinical records do not support treating this patient with Nalfon. It is being started in conjunction with Fexmid, which means that it would be impossible to determine which medication is producing any side effect or beneficial effect that occurs. The patient has not demonstrated any functional improvement with long-term use of other NSAIDs, and Nalfon is no more likely to cause functional improvement than any of the NSAIDs previously used. This patient has both hypertension and diabetes. Although her primary treater has not recorded her medications for these conditions, she can be presumed to be on an ACE inhibitor, which is the most frequently prescribed type of blood pressure medication for people who have diabetes. The patient's blood pressure was noted to be uncontrolled by the primary treater at the time he prescribed Nalfon. Since Nalfon (or any other NSAID) is likely to raise the patient's blood pressure further, it is medically contraindicated. In addition, hypertension and diabetes put this patient at risk for coronary artery disease. An NSAID puts her at increased risk for a cardiovascular event, which does not appear to be justified by the minimal benefits they have provided her in the past. Based on the MTUS citations above and on the clinical findings provided for my review, Nalfon 400mg #60 is not medically necessary, because is being started in conjunction with another medication, because it is not indicated for long-term use for this patient's pain, because similar medications have not produced significant functional recovery in the past, because it may raise her blood pressure, and because it increases her risk for cardiovascular events.

**Retrospective Fluoroscopy (DOS: 9/8/14): 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), Wrist and Hand Chapter, Radiography and other Medical Treatment Guideline or Medical Evidence: UptoDate, an on-line, evidence-based review service for clinicians ([www.uptodate.com](http://www.uptodate.com)), Clinical manifestations and diagnosis of carpal tunnel syndrome and American College of Radiology Appropriateness Criteria, Musculoskeletal section, Chronic Wrist Pain.

**Decision rationale:** Fluoroscopy is an imaging technique that uses x-rays to obtain real-time moving images. It is usually used to visualize a part of the body that moves such as the heart, or to assist a clinician in the placement of a moveable object such as a needle. It typically exposes the patient to more ionizing radiation than does a plain x-ray. In this case, the fluoroscopy in question was performed with an in-office fluoroscope, which at least some physicians use primarily to generate revenue. The ODG reference above states that plain x-rays are indicated for patients with known or suspected wrist fractures. Fluoroscopic spot films may be useful in identifying fractures when the initial plain x-ray is equivocal, or when it is negative but the patient still has signs and symptoms of a fracture. Plain x-rays are recommended for initial evaluation of chronic wrist pain. According to the UptoDate reference above, imaging studies are not routinely employed in the evaluation of carpal tunnel syndrome. MRI can detect abnormalities of the median nerve, flexor tendons, vascular structures, and transverse carpal ligament in the region of the carpal tunnel, but the diagnostic utility of MRI for CTS remains uncertain. The ACR Appropriateness Criteria list multiple possible imaging procedures and rank their appropriateness for various chronic wrist pain scenarios. The most appropriate procedures after plain x-ray include MRI, MR arthrography, ultrasound, CT scan, or CT arthrography for all scenarios. Fluoroscopy is not even listed as a possibly useful imaging technique for chronic wrist pain except for the case where wrist aspiration is indicated to rule out infection, and imaging guidance is necessary. The clinical documentation in this case does not support the performance of wrist fluoroscopy. The provider has given no rationale for performing it. The findings he recorded could have been, and probably already were already provided by plain x-ray. The provider did not record any suspicion for occult fracture or of a need for aspiration that would have required fluoroscopy. In short, he performed a procedure that needlessly exposed this patient to radiation without providing any reason for performing it, and obtained results that could have been obtained by plain x-ray or by review of plain x-rays previously performed. Based on the evidence-based citations above and on the clinical documentation provided for my review, fluoroscopy of the right wrist was not medically necessary because the provide did not document a reason for performing it, and because it exposed the patient to needlessly high radiation levels to produce results that could have been better obtained by other imaging methods.