

Case Number:	CM14-0029041		
Date Assigned:	07/07/2014	Date of Injury:	10/15/2013
Decision Date:	12/08/2014	UR Denial Date:	02/07/2014
Priority:	Standard	Application Received:	03/06/2014

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 Occupational 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:

According to the records made available for review, this is a 46-year-old male with a 10/15/13 date of injury. At the time (12/31/13) of request for authorization for X-Rays (unspecified), MRI (not specified), EMG/NCV, Functional Capacity Evaluation, Acupuncture (not specified), Physical Therapy, Shockwave, Neurological Consultation, TENS Unit, Compounded Ketoprofen, Compounded Cyclophene, Synapryn, Tabradol, Deprizine, Dicopanol, Fanatrex, and Hot/cold unit, there is documentation of subjective (radiating neck pain with numbness and tingling in the bilateral upper extremities; radiating low back pain with numbness and tingling in the bilateral lower extremities; and bilateral shoulder pain radiating to the wrists with numbness and tingling) and objective (trigger points over the upper trapezius, decreased range of motion, tenderness over the supraspinatus and infraspinatus muscles, decreased sensation over the right upper extremity, decreased motor strength in the bilateral upper extremity, and decreased sensation over the right lower extremity) findings. The current diagnoses are cervical pain herniated nucleus pulposus (HNP), cervical radiculopathy, rule out bilateral shoulder rotator cuff tear, right wrist triangular fibro cartilaginous complex (TFCC) tear, thoracic spine sprain/strain, lumbar spine herniated nucleus pulposus (HNP), and lumbar radiculopathy. The treatment to date includes Nabumetone, Tramadol, polar frost, Tylenol, and Relafen and physical therapy. Medical reports identify that patient reports worsening symptoms with therapy and medications. Regarding Functional Capacity Evaluation, there is no documentation indicating case management is hampered by complex issues (prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modified job, injuries that require detailed exploration of a worker's abilities); and timing is appropriate (Close to or at maximum medical improvement/all key medical reports secured and additional/secondary conditions have been clarified). Regarding Physical Therapy, the number of previous physical therapy treatments

cannot be determined; and there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy provided to date. Regarding Neurological Consultation, there is no documentation of persistent, severe, and disabling shoulder or arm symptoms, activity limitation for more than one month or with extreme progression of symptoms, clear clinical, imaging, and electrophysiology evidence, consistently indicating the same lesion that has been shown to benefit from surgical repair both in the short and the long term, and unresolved radicular symptoms. Regarding TENS Unit, there is no documentation that other appropriate pain modalities have been tried (including medication) and failed, a statement identifying that the TENS unit will be used as an adjunct to a program of evidence-based functional restoration, and a treatment plan including the specific short- and long-term goals of treatment with the TENS. Regarding Compounded Cyclophene, there is no documentation of neuropathic pain when trials of antidepressants and anticonvulsants have failed.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-Rays (unspecified): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: MTUS reference to ACOEM guidelines identifies documentation of emergence of red flag, physiological evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, or clarification of anatomy prior to an invasive procedure, as criteria necessary to support the medical necessity of cervical spine x-rays. Within the medical information available for review, there is documentation of diagnoses of cervical pain HNP, cervical radiculopathy, rule out bilateral shoulder rotator cuff tear, right wrist TFCC tear, thoracic spine sprain/strain, lumbar spine HNP, and lumbar radiculopathy. However, there is no documentation of the specific body parts for this request. Therefore, based on guidelines and a review of the evidence, the request for X-Rays (unspecified) is not medically necessary.

MRI (not specified): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-183.

Decision rationale: MTUS reference to ACOEM Guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative, physiologic evidence (in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans) of tissue insult or neurologic dysfunction, failure of conservative treatment; or diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure; as criteria necessary to support the medical necessity of an MRI. Within the medical information available for review, there is documentation of diagnoses of cervical pain HNP, cervical radiculopathy, rule out bilateral shoulder rotator cuff tear, right wrist TFCC tear, thoracic spine sprain/strain, lumbar spine HNP, and lumbar radiculopathy. However, there is no documentation of the specific body part being requested for the MRI. Therefore, based on guidelines and a review of the evidence, the request for MRI (not specified) is not medically necessary.

EMG/NCV: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177; 33.

Decision rationale: MTUS reference to ACOEM identifies documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment, as criteria necessary to support the medical necessity of EMG/NCV. Within the medical information available for review, there is documentation of diagnoses of cervical pain HNP, cervical radiculopathy, rule out bilateral shoulder rotator cuff tear, right wrist TFCC tear, thoracic spine sprain/strain, lumbar spine HNP, and lumbar radiculopathy. However, there is no documentation of the specific body(s) for the EMG/NCV. Therefore, based on guidelines and a review of the evidence, the request for EMG/NCV is not medically necessary.

Acupuncture (not specified): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: MTUS Acupuncture Medical Treatment Guidelines identifies that acupuncture may be used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery, to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. In addition, MTUS Acupuncture Medical Treatment Guidelines allow the use of acupuncture for musculoskeletal conditions for a frequency and duration of treatment as follows: Time to produce functional improvement of 3-6 treatments, frequency of 1-3 times

per week, and duration of 1-2 months. Within the medical information available for review, there is documentation of diagnoses of cervical pain HNP, cervical radiculopathy, rule out bilateral shoulder rotator cuff tear, right wrist TFCC tear, thoracic spine sprain/strain, lumbar spine HNP, and lumbar radiculopathy. However, there is no documentation of the specific body(s) parts for the requested acupuncture treatment. Therefore, based on guidelines and a review of the evidence, the request for Acupuncture (not specified) is not medically necessary.

Physical Therapy: 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 Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Physical Therapy (PT); Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Official Disability Guidelines notes patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of cervical pain HNP, cervical radiculopathy, rule out bilateral shoulder rotator cuff tear, right wrist TFCC tear, thoracic spine sprain/strain, lumbar spine HNP, and lumbar radiculopathy. In addition, there is documentation of previous physical therapy treatments. However, there is no documentation of the specific body(s) parts for the requested physical therapy treatment. In addition, there is no documentation of the number of previous physical therapy sessions and, if the number of treatments has exceeded guidelines, remaining functional deficits that would be considered exceptional factors to justify exceeding guidelines. Furthermore, given documentation that patient reports worsening symptoms with therapy, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy provided to date. Therefore, based on guidelines and a review of the evidence, the request for Physical Therapy is not medically necessary.

Shockwave: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 44.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007) Page(s): 203; 29. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Extracorporeal Shock Wave Therapy (ESWT)

Decision rationale: MTUS reference to ACOEM Guidelines identifies some medium quality evidence supporting manual physical therapy, ultrasound, and high energy extracorporeal shock wave therapy for calcifying tendinitis of the shoulder. In addition, MTUS reference to ACOEM Guidelines state there is a recommendation against using extracorporeal shockwave therapy for evaluating and managing elbow complaints. Official Disability Guidelines identifies documentation of pain from calcifying tendinitis of the shoulder has remained despite six months of standard treatment; at least three conservative treatments have been performed prior to use of ESWT (a. Rest, b. Ice, c. NSAIDs, d. Orthotics, e. Physical Therapy, e. Injections (Cortisone)); and absence of contraindications (Patients younger than 18 years of age; Patients with blood clotting diseases, infections, tumors, cervical compression, arthritis of the spine or arm, or nerve damage; Patients with cardiac pacemakers; Patients who had physical or occupational therapy within the past 4 weeks; Patients who received a local steroid injection within the past 6 weeks; Patients with bilateral pain; Patients who had previous surgery for the condition), as criteria necessary to support the medical necessity of extracorporeal shockwave treatment for the shoulder. Within the medical information available for review, there is documentation of diagnoses of cervical pain HNP, cervical radiculopathy, rule out bilateral shoulder rotator cuff tear, right wrist TFCC tear, thoracic spine sprain/strain, lumbar spine HNP, and lumbar radiculopathy. However, there is no documentation of the specific body(s) parts for the requested shockwave treatment. Therefore, based on guidelines and a review of the evidence, the request for Shockwave is not medically necessary.

Neurological Consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180.

Decision rationale: MTUS reference to ACOEM Guidelines identifies documentation of persistent, severe, and disabling shoulder or arm symptoms, activity limitation for more than one month or with extreme progression of symptoms, clear clinical, imaging, and electrophysiology evidence, consistently indicating the same lesion that has been shown to benefit from surgical repair both in the short and the long term, and unresolved radicular symptoms, as criteria necessary to support the medical necessity of a spine specialist referral. Within the medical information available for review, there is documentation of diagnoses of cervical pain HNP, cervical radiculopathy, rule out bilateral shoulder rotator cuff tear, right wrist TFCC tear, thoracic spine sprain/strain, lumbar spine HNP, and lumbar radiculopathy. However, there is no documentation of persistent, severe, and disabling shoulder or arm symptoms, activity limitation for more than one month or with extreme progression of symptoms, clear clinical, imaging, and

electrophysiology evidence, consistently indicating the same lesion that has been shown to benefit from surgical repair both in the short and the long term, and unresolved radicular symptoms. In addition, there is no documentation of a rationale identifying the medical necessity of the requested consultation. Therefore, based on guidelines and a review of the evidence, the request for Neurological Consultation is not medically necessary.

TENS Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation Page(s): 113-117.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, a statement identifying that the TENS unit will be used as an adjunct to a program of evidence-based functional restoration, and a treatment plan including the specific short- and long-term goals of treatment with the TENS, as criteria necessary to support the medical necessity of a month trial of a TENS unit. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of how often the unit was used, outcomes in terms of pain relief and function, and other ongoing pain treatment during the trial period (including medication use), as criteria necessary to support the medical necessity of continued TENS unit. Within the medical information available for review, there is documentation of diagnoses of cervical pain HNP, cervical radiculopathy, rule out bilateral shoulder rotator cuff tear, right wrist TFCC tear, thoracic spine sprain/strain, lumbar spine HNP, and lumbar radiculopathy. In addition, there is documentation of pain of at least three months duration. However, given the associated therapeutic requests, there is no documentation that other appropriate pain modalities have been tried (including medication) and failed. In addition, there is no documentation of a statement identifying that the TENS unit will be used as an adjunct to a program of evidence-based functional restoration and a treatment plan including the specific short- and long-term goals of treatment with the TENS. Therefore, based on guidelines and a review of the evidence, the request for TENS Unit is not medically necessary.

Functional Capacity Evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 44.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and Consultations, page(s) 137-138 and Official Disability Guidelines (ODG) Fitness For Duty, Functional capacity evaluation (FCE)

Decision rationale: MTUS reference to ACOEM guidelines identifies that functional capacity evaluations (FCE) may establish physical abilities and also facilitate the examinee/employer relationship for return to work. Official Disability Guidelines identifies documentation indicating case management is hampered by complex issues (prior unsuccessful RTW attempts, conflicting medical reporting on precautions and/or fitness for modified job, injuries that require detailed exploration of a worker's abilities); and timing is appropriate (Close to or at MMI/all key medical reports secured and additional/secondary conditions have been clarified), as criteria necessary to support the medical necessity of a functional capacity evaluation. Within the medical information available for review, there is documentation of diagnoses of cervical pain HNP, cervical radiculopathy, rule out bilateral shoulder rotator cuff tear, right wrist TFCC tear, thoracic spine sprain/strain, lumbar spine HNP, and lumbar radiculopathy. However, there is no documentation indicating case management is hampered by complex issues (prior unsuccessful RTW attempts, conflicting medical reporting on precautions and/or fitness for modified job, injuries that require detailed exploration of a worker's abilities); and timing is appropriate (Close to or at MMI/all key medical reports secured and additional/secondary conditions have been clarified). Therefore, based on guidelines and a review of the evidence, the request for Functional Capacity Evaluation is not medically necessary.

Compounded Ketoprofen: 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): 111-113.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that many agents are compounded as monotherapy or in combination for pain control; that Ketoprofen, Lidocaine (in creams, lotion or gels), Capsaicin in a 0.0375% formulation, Baclofen and other muscle relaxants, and Gabapentin and other anti-epilepsy drugs are not recommended for topical applications; and that any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Therefore, based on guidelines and a review of the evidence, the request for Compounded Ketoprofen is not medically necessary.

Compounded Cyclophene: 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: MTUS Chronic Pain Medical Treatment Guidelines identifies that topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Within the medical information available for review, there is documentation of diagnoses of cervical pain HNP, cervical radiculopathy, rule out bilateral

shoulder rotator cuff tear, right wrist TFCC tear, thoracic spine sprain/strain, lumbar spine HNP, and lumbar radiculopathy. However, there is no documentation of neuropathic pain when trials of antidepressants and anticonvulsants have failed. Therefore, based on guidelines and a review of the evidence, the request for Compounded Cyclophene is not medically necessary.

Synapryn: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Management

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Co-pack drugs; Other Medical Treatment Guideline or Medical Evidence:
(<http://www.drugs.com/cons/fusepaq-synapryn.html>)

Decision rationale: Medical Treatment Guidelines identify Synapryn as Tramadol hydrochloride, in oral suspension with glucosamine-compounding kit. MTUS does not address the issue. Official Disability Guidelines identifies that co-packs are convenience packaging of a medical food product and a generic drug into a single package that requires a prescription. While the generic drug is FDA-approved, the co-pack of a medical food and FDA-approved drug is not unless the manufacturer obtains FDA approval for the product as a new drug. There are no high quality medical studies to evaluate co-packs on patient outcomes. Therefore, based on guidelines and a review of the evidence, the request for Synapryn is not medically necessary.

Tabradol: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Management

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Co-pack drugs; Other Medical Treatment Guideline or Medical Evidence:
(<http://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=22434>)

Decision rationale: Medical Treatment Guidelines identify Tabradol as Cyclobenzaprine hydrochloride, in oral suspension with MSM - compounding kit. MTUS does not address the issue. Official Disability Guidelines identifies that co-packs are convenience packaging of a medical food product and a generic drug into a single package that requires a prescription. While the generic drug is FDA-approved, the co-pack of a medical food and FDA-approved drug is not unless the manufacturer obtains FDA approval for the product as a new drug. There are no high quality medical studies to evaluate co-packs on patient outcomes. Therefore, based on guidelines and a review of the evidence, the request for Tabradol is not medically necessary.

Deprizine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Management

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Co-pack drugs; Other Medical Treatment Guideline or Medical Evidence: (<http://www.drugs.com/pro/deprizine.html>)

Decision rationale: Medical Treatment Guideline identifies Deprizine as Ranitidine hydrochloride in oral suspension kit. MTUS does not address the issue. Official Disability Guidelines identifies that co-packs are convenience packaging of a medical food product and a generic drug into a single package that requires a prescription. While the generic drug is FDA-approved, the co-pack of a medical food and FDA-approved drug is not unless the manufacturer obtains FDA approval for the product as a new drug. There are no high quality medical studies to evaluate co-packs on patient outcomes. Therefore, based on guidelines and a review of the evidence, the request for Deprizine is not medically necessary.

Dicopanorl: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Management

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Co-pack drugs; Other Medical Treatment Guideline or Medical Evidence: (<http://www.drugs.com/pro/dicopanorl.html>)

Decision rationale: Medical Treatment Guideline identifies Dicopanorl as Diphenhydramine hydrochloride in oral suspension - compounding kit. MTUS does not address the issue. Official Disability Guidelines identifies that co-packs are convenience packaging of a medical food product and a generic drug into a single package that requires a prescription. While the generic drug is FDA-approved, the co-pack of a medical food and FDA-approved drug is not unless the manufacturer obtains FDA approval for the product as a new drug. There are no high quality medical studies to evaluate co-packs on patient outcomes. Therefore, based on guidelines and a review of the evidence, the request for Dicopanorl is not medically necessary.