

Case Number:	CM14-0197004		
Date Assigned:	12/16/2014	Date of Injury:	04/01/2013
Decision Date:	01/31/2015	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	11/24/2014

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 Rehab, 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 65 year old male with an injury date on 04/01/2013. Based on the 08/29/2014 progress report provided by the treating physician, the diagnoses are: 1. Lumbar spine HNP 2. Radiculopathy, lumbar region 3. Low back pain 4. Left hip internal derangement 5. Status post fracture of head and neck of femur 6. Status post surgery 7. Pain in left thigh 8. Status post fracture of lower end of femur 9. Sprain of unspecified site of left knee 10. Tear of medial meniscus, current injury, left knee 11. R/O Chondromalacia patellae, left knee

According to this report, the patient complains of constant, moderate to severe "sharp, stabbing, radicular low back pain and muscle spasms." Pain is rated as a 7-8/10. The pain is associated with numbness and tingling of the bilateral lower extremities. The pain aggravated by prolonged positioning including sitting, standing, walking, bending, arising from a sitting position, ascending or descending stairs, stooping, activities of daily living such as getting dressed and performing personal hygiene. The patient also complains of constant, moderate to severe "sharp, stabbing left knee pain and muscle spasms" that is an 8/10 on a pain analog scale. The pain is aggravated with squatting, kneeling ascending or descending stairs, prolonged position including weight bearing, standing and walking. Physical exam demonstrates tenderness at the spinous processes of L2-L5, left great trochanter, left iliotibial band, left anterior tibia, medial/lateral joint lines of the left knee, left patellofemoral joint. Range of motion of the lumbar spine, left hip, and left knee is restricted. Straight leg raise, Patrick's, McMurray's, Lachman's, Varus, and Crunch test are positive. Decrease sensation to pin-prick and light touch is noted at the left L5-S1 dermatomes. Motor strength is decrease at the bilateral lower extremities secondary to pain. The treatment plan is to refill medications, undergo a course of shockwave therapy for the left hip (3 sessions), lumbar spine (6 sessions), and LINT for the lumbar spine (6 sessions), and return for a follow-up evaluation in 4 weeks. The patient's work status is "remain

off-work- TTD from 08/29/2014 to 09/30/2014." There were no other significant findings noted on this report. The utilization review denied the request for ESWT of the left hip/ lumbar spine, LINT, Terocin patches, Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclobenzaprine topical cream, and Ketoprofen topical cream on 10/30/2014 based on the MTUS/ODG guidelines. The requesting physician provided treatment reports from 03/31/2014 to 12/19/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Extracorporeal shockwave therapy (ESWT) - left hip, 3 sessions between 8/29/14-12/26/14:
Upheld

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

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: shockwave therapy;
http://www.emblemhealth.com/~media/Files/PDF/_med_guidelines/MG_ESWT_Musculoskeletal_a.pdf

Decision rationale: According to the 08/29/2014 report, this patient presents with constant, moderate to severe sharp, stabbing low back and left knee pain with muscle spasms. The current request is for extracorporeal shockwave therapy (ESWT) - left hip, 3 sessions between 8/29/14-12/26/14. Regarding extracorporeal shockwave therapy, MTUS and ODG does not discuss ESWT for the hip. However, the Emblem Health guidelines based on Medicare state, "ESWT is not considered medically necessary for indications other than epicondylitis or plantar fasciitis." In this case the treating physician has requested ESWT of the hip and the guidelines stated do not support ESWT for the treatment of hip internal derangement as this patient presents with. The current request is not medically necessary.

ESWT - lumbar spine, 6 sessions between 8/29/14-12/26/14: Upheld

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

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: Shockwave Therapy

Decision rationale: According to the 08/29/2014 report, this patient presents with constant, moderate to severe sharp, stabbing low back and left knee pain with muscle spasms. The current request is for ESWT - lumbar spine, 6 sessions between 8/29/14-12/26/14. Regarding extracorporeal shockwave therapy for the low back, 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)." The current request is not medically necessary.

Intense, localized neurostimulation therapy (LINT) - left hip, 6 sessions between 8/29/14-12/26/14: 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) Low back chapter under Hyperstimulation analgesia

Decision rationale: According to the 08/29/2014 report, this patient presents with constant, moderate to severe sharp, stabbing low back and left knee pain with muscle spasms. The current request is for intense, localized neurostimulation therapy (LINT) - left hip, 6 sessions between 8/29/14-12/26/14. 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. Therefore, the current request is not medically necessary.

Terocin patches (unknown dose and number) between 8/29/14-12/26/14: 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 Cream Page(s): 111-113.

Decision rationale: According to the 08/29/2014 report, this patient presents with constant, moderate to severe sharp, stabbing low back and left knee pain with muscle spasms. The current request is for Terocin patches (unknown dose and number) between 8/29/14-12/26/14. Terocin patches are a dermal patch with 4% lidocaine, and 4% menthol. The MTUS guidelines state that Lidocaine patches may be recommended for neuropathic pain that is peripheral and localized when trials of antidepressants and anti-convulsion have failed. ODG further requires documentation of the area for treatment, trial of a short-term use with outcome documenting pain and function. In this case, this patient presents with lumbar spine neuropathic pain but is not peripheral and localized; and localized lower extremity pain but it is not neuropathic pain. The treating physician has not documented that a trial of anti-depressants and anti-convulsion have failed, the location of trial of the Lidoderm patches is not stated. Furthermore, Lidoderm patches are not recommended for axial back pain but peripheral, localized neuropathic pain. The current request is not medically necessary.

Deprizine (unknown dose and number) between 8/29/14-12/26/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GI Symptoms & Cardiovascular Risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPI: NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 69.

Decision rationale: According to the 08/29/2014 report, this patient presents with constant, moderate to severe sharp, stabbing low back and left knee pain with muscle spasms. The current request is for Deprizine (unknown dose and number) between 8/29/14-12/26/14 and this medication was first noted in the 03/31/2014 report. The MTUS page 69 states under NSAIDs prophylaxis to discuss; GI symptoms & cardiovascular risk and 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 > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)."MTUs further states "Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI."Review of the reports show that the patient is not currently on NSAID and has no gastrointestinal side effects with medication use. The patient is not over 65 years old; no other risk factors are present. The treating physician does not mention if the patient is struggling with GI complaints and why the medication was prescribed. There is no discussion regarding GI assessment as required by MTUS. MTUS does not recommend routine use of GI prophylaxis without documentation of GI risk. In addition, the treating physician does not mention symptoms of gastritis, reflux or other condition that would require a PPI. Therefore, the request is not medically necessary.

Dicoprofanol (unknown dose and number) between 8/29/14-12/26/14: 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) mental illness under Diphenhydramine (Benadryl)

Decision rationale: According to the 08/29/2014 report, this patient presents with constant, moderate to severe sharp, stabbing low back and left knee pain with muscle spasms. The current request is for Dicoprofanol (unknown dose and number) between 8/29/14-12/26/14. Dicoprofanol is diphenhydramine 5mg/ml in an oral suspension with other proprietary ingredients. Regarding diphenhydramine, ODG guidelines state "sedating antihistamines are not recommended for long-term insomnia treatment. The AGS updated Beers criteria for inappropriate medication use includes diphenhydramine. (AGS, 2012)."Review of the reports does not show the patient has sleeping issue. In this case, the treating physician is requesting Dicoprofanol and this medication were first noted in the 03/31/2014 report. Dicoprofanol is not recommended for long term use. The treating physician does not mention that this is for a short-term use. Therefore, the current request is not medically necessary.

Fanatrex (unknown dose and number) between 8/29/14-12/26/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Antiepilepsy Drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs), Medications for chronic pain Page(s): 16-18, 60, 61.

Decision rationale: According to the 08/29/2014 report, this patient presents with constant, moderate to severe sharp, stabbing low back and left knee pain with muscle spasms. The current request is for Fanatrex (unknown dose and number) between 8/29/14-12/26/14. This medication was first mentioned in the 03/31/2014 report; it is unknown exactly when the patient initially started taking this medication. 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 the reports indicates that the patient has neuropathic pain. The ODG guidelines support the use of anti-convulsants for neuropathic pain. However, the treating physician did not provide discussion regarding the efficacy of the medication. MTUS page 60 require that medication efficacy in terms of pain reduction and functional gains must be discussed when used for chronic pain. The request is not medically necessary.

Synapryn (unknown dose and number) between 8/29/14-12/26/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain, Criteria for Use of Opioids Page(s): 60, 61, 88, 89, 76-78.

Decision rationale: According to the 08/29/2014 report, this patient presents with constant, moderate to severe sharp, stabbing low back and left knee pain with muscle spasms. The current request is for Synapryn (unknown dose and number) between 8/29/14-12/26/14. Synapryn (Tramadol) was first mentioned in 03/31/2014 report; it is unknown exactly when the patient initially started taking this medication. 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 4A's (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. In this case, the reports show documentation of pain assessment but no before and after analgesia is provided. ADL's are mentioned as above but no documentation as to how this medication is significantly improving the patient's ADL's and daily function. No return to work or opiate monitoring is discussed such as urine toxicology and CURES. Outcome measures are not documented as required by MTUS. No valid instruments are used to measure the patient's function which is recommended once at least every 6 months per MTUS. The treating physician

has failed to clearly document 4 A's as required by MTUS. The request is not medically necessary.

Tabradol (unknown dose and number) between 8/29/14-12/26/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants, (for pain) Page(s): 64, 63.

Decision rationale: According to the 08/29/2014 report, this patient presents with constant, moderate to severe sharp, stabbing low back and left knee pain with muscle spasms. The current request is for Tabradol (unknown dose and number) between 8/29/14-12/26/14. For muscle relaxants for pain, the MTUS Guidelines page 63 state "Recommended non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbation in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension and increasing mobility; however, in most LBP cases, they showed no benefit beyond NSAIDs and pain and overall improvement." A short course of muscle relaxant may be warranted for patient's reduction of pain and muscle spasms. Review of the available records indicates this patient has been prescribed this medication longer than the recommended 2-3 weeks. The treating physician is requesting Tabradol and this medication was first noted in the 03/31/2014 report. Tabradol is not recommended for long term use. The treating physician does not mention that this is for a short-term use to address a flare-up or an exacerbation. Therefore, the current request is not medically necessary.

Cyclobenzaprine topical cream (unknown dose and number) between 8/29/14-12/26/14: Upheld

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

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

Decision rationale: According to the 08/29/2014 report, this patient presents with constant, moderate to severe sharp, stabbing low back and left knee pain with muscle spasms. The current request is for Cyclobenzaprine topical cream (unknown dose and number) between 8/29/14-12/26/14. Regarding topical compounds, MTUS states that if one of the compounded products is not recommended then the entire compound is not recommended." MTUS further states Cyclobenzaprine topical, other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product. In this case, Cyclobenzaprine cream is not recommended for topical formulation. The current request is not medically necessary.

Ketoprofen topical cream (unknown dose and number) between 8/29/14-12/26/14: Upheld

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

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

Decision rationale: According to the 08/29/2014 report, this patient presents with constant, moderate to severe sharp, stabbing low back and left knee pain with muscle spasms. The current request is for Ketoprofen topical cream (unknown dose and number) between 8/29/14-12/26/14. Regarding Ketoprofen topical cream, MTUS states "Non FDA-approved agents: Ketoprofen: This agent is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. (Diaz, 2006) (Hindsen, 2006)." In this case, Ketoprofen cream is not recommended for topical formulation. The current request is not medically necessary.