

Case Number:	CM14-0203876		
Date Assigned:	02/06/2015	Date of Injury:	05/13/2002
Decision Date:	03/26/2015	UR Denial Date:	11/25/2014
Priority:	Standard	Application Received:	12/05/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New York
 Certification(s)/Specialty: Emergency Medicine

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 injured worker is a 55 year-old male who has reported the gradual onset of widespread pain attributed to usual work activity, with a listed injury date of 5/13/2002. He has reported pain in the neck, shoulders, elbows, wrists, and low back. The diagnoses have included status post left carpal tunnel release, bilateral impingement syndrome, epicondylitis, and lumbar disc displacement with radiculopathy. Treatment to date has included NSAIDs, analgesics, surgery, physical therapy, and acupuncture. Reports from the treating physician over the course of the last year do not address the specific indications or results for any medication. The injured worker continued to have ongoing pain and was stated to be temporarily totally disabled. No medications were prescribed individually, one at a time, and given a trial period to assess results. Medications were prescribed together with no individual assessment. It appears that the currently requested medications are those which have been given chronically. Right and left shoulder MRIs on 9/13/14 showed degenerative changes, with no calcific tendinitis. A weight-bearing MRI on 9/12/14 showed degenerative changes with no surgical pathology. As of 10/1/14 there was ongoing neck, shoulder, upper extremity, elbow, wrist, and low back pain. There was widespread and non-specific tenderness, limited range of motion, and weakness. The treatment plan included the items now under Independent Medical Review. The orthopedic consultation was for the low back and wrists, with no specified indications. The specific indications for the MRIs were not stated. The specific indications for the therapies were not discussed. Attached to the report were generic information statements about the various medications, tests, and therapies, with no patient-specific information. On 11/25/2014 Utilization Review non-certified

Terocin Patches, trigger point impedance imaging, elbow MRIs, wrist MRIs, orthopedic consultation, shockwave therapy, LINT, Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclobenzaprine topical gel, and Ketoprofen. The MTUS and ACOEM Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Terocin patches (unknown prescription) (between 10/1/14 and 1/18/2015): 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; Topical Analgesics Page(s): 60; 111-113.

Decision rationale: The treating physician has not discussed the ingredients of Terocin and the specific indications for this injured worker. Per the manufacturer, Terocin is Methyl Salicylate 25%, Menthol 10%, Capsaicin 0.025%, Lidocaine 2.5%, Aloe, Borage Oil, Boswellia Serrata, and other inactive ingredients. Per page 60 of the MTUS, medications should be trialed one at a time. Regardless of any specific medication contraindications for this patient, the MTUS recommends against starting 3-7 medications simultaneously. Per the MTUS, any compounded product that contains at least one drug that is not recommended, is not recommended. Boswellia serrata resin and topical lidocaine other than Lidoderm are not recommended per the MTUS. Capsaicin alone in the standard formulation readily available OTC may be indicated for some patients. The indication in this case is unknown, as the patient has not failed adequate trials of other treatments. Capsaicin is also available OTC, and the reason for compounding the formula you have prescribed is not clear. Terocin is not medically necessary based on lack of specific medical indications, the MTUS, lack of medical evidence, FDA directives, and inappropriate prescribing.

trigger point impedance imaging (TPII) - 9 sessions (between 10/1/14 and 1/18/2015): 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) Pain chapter, Hyperstimulation analgesia

Decision rationale: The MTUS does not address TPII and LINT. The Official Disability Guidelines recommend against these procedures based on the lack of medical evidence. The TPII is therefore not medically necessary.

MRI study - both elbows (between 10/1/14 and 1/18/2015): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 35.

Decision rationale: Per the ACOEM Guidelines for the Elbow, Page 35, Special Studies and Diagnostic and Treatment Considerations, criteria for ordering imaging studies are: The imaging study results will substantially change the treatment plan. Emergence of a red flag. Failure to progress in a rehabilitation program, evidence of significant tissue insult or neurological dysfunction that has been shown to be correctible by invasive treatment, and agreement by the patient to undergo invasive treatment if the presence of the correctible lesion is confirmed. The treating physician has not provided evidence of a red flag condition, a surgical condition, or discussed the failure of a specific rehabilitative program. The tests are therefore not medically necessary.

MRI study - both wrists (between 10/1/14 and 1/18/2015): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 254-258; 268-269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, hand, wrist chapter; MRI's (magnetic resonance imaging)

Decision rationale: The ACOEM Guidelines pages 254-258 list the criteria for examining the hand and wrist. The necessary components of the examination are not present. The specific historical details of any wrist symptoms are not described sufficiently. Per Page 268-269 of the ACOEM Guidelines, special studies are not needed until after a 4-week period of conservative care. Common tests are listed, with indications. Specific care for the wrist was not described adequately. The treating physician has not provided sufficient indications for any imaging test, including an MRI. The Official Disability Guidelines list the following indications for an MRI in the setting of chronic pain:- Chronic wrist pain, plain films normal, suspect soft tissue tumor- Chronic wrist pain, plain film normal or equivocal, suspect Kienbeck's disease. None of these conditions were described by the treating physician. The wrist MRIs are not medically necessary based on the lack of sufficient indications and the cited guidelines.

orthopedic surgeon regarding lumbar spine and both wrists (between 10/1/14 and 1/18/2015): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 270; 305.

Decision rationale: Per the cited guidelines referral for hand surgery consultation may be indicated for patients who: Have red flags of a serious nature. Fail to respond to conservative management, including worksite modifications. Have clear clinical and special study evidence of

a lesion that has been shown to benefit, in the both the short and long term, from surgical intervention. The treating physician has not adequately described any red flag conditions, specific failed conservative care, and evidence of a surgical lesion. The referral for the wrists is therefore not medically necessary. The treating physician has not provided the specific indications for spine surgery, per the criteria in the MTUS. He has not described any specific and objective surgical pathology in his recent reports. The MRI, though of questionable validity as it was a weight bearing study, did not show surgical pathology. The MTUS recommends surgical consultation for patients who have clear signs and symptoms of a specific lesion that is established to respond well to surgery in the short and long term. The referral is not medically necessary as the treating physician has not provided sufficient evidence of surgical pathology.

shockwave therapy for both shoulders, elbows, and wrists - 3 sessions (between 10/1/14 and 1/18/2015): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007) Page(s): 203; 29.

Decision rationale: The MTUS strongly recommends against extracorporeal shock wave lithotripsy for the elbow, as it has been proven to be ineffective. The extracorporeal shock wave lithotripsy in this case is not medically necessary based on the MTUS and lack of supporting medical evidence. The MTUS, cited above, states that ECSWT is an option for calcifying tendinitis. This condition is not present in this injured worker, per the MRI findings. The ECSWT is not medically necessary as a result. The MTUS does not provide direction for using ECSWT for the wrist, but the request is already not medically necessary based on the shoulders and elbows.

shockwave therapy for cervical and lumbar spine - 6 sessions (between 10/1/14 and 1/18/2015): 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, Shock wave therapy

Decision rationale: The MTUS does not provide direction for shock wave therapy for low back pain. The Official Disability Guidelines cited above recommend against this therapy. It is therefore not medically necessary. The MTUS and the Official Disability Guidelines do not comment on shockwave therapy for the neck but this request already not medically necessary based on the lumbar component of the request.

localized intense neurostimulation therapy for lumbar spine - 9 sessions (between 10/1/14 and 1/18/2015): 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) Pain chapter, Hyperstimulation analgesia

Decision rationale: The MTUS does not address TPII and LINT. The Official Disability Guidelines recommend against these procedures based on the lack of medical evidence. The TPII is therefore not medically necessary.

Deprizine - unknown prescription (between 10/1/14 and 1/18/2015): 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: Deprizine is ranitidine in an oral suspension. Ranitidine is prescribed without any patient-specific rationale provided. If ranitidine is prescribed as cotherapy with an NSAID, ranitidine is not the best drug. Note the MTUS recommendations cited. There are no medical reports which adequately describe the relevant signs and symptoms of possible GI disease. There is no examination of the abdomen on record. There are many possible etiologies for GI symptoms; the available reports do not provide adequate consideration of these possibilities. Empiric treatment after minimal evaluation is not indicated. Cotherapy with an NSAID is not indicated in patients other than those at high risk. No reports describe the specific risk factors present in this case. The request does not contain a quantity, directions, or duration. Ranitidine is not medically necessary based on the MTUS.

Dicopanor - unknown prescription (between 10/1/14 and 1/18/2015): 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) Official Disability Guidelines, Pain chapter, Insomnia

Decision rationale: The treating physician has stated that Dicopanor is diphenhydramine and other unnamed ingredients. Medical necessity cannot be determined for unspecified compounds, and unpublished ingredients cannot be assumed to be safe or effective. Dicopanor is not medically necessary on this basis alone. In addition, Dicopanor is stated to be for insomnia. The MTUS does not address the use of hypnotics other than benzodiazepines. No physician reports describe the specific criteria for a sleep disorder. Treatment of a sleep disorder, including

prescribing hypnotics, should not be initiated without a careful diagnosis. There is no evidence of that in this case. Note the Official Disability Guidelines citation above. That citation also states that antihistamines are not indicated for long term use as tolerance develops quickly, and that there are many, significant side effects. The request does not contain a quantity, directions, or duration. Dicopanol is not medically necessary based on lack of a sufficient analysis of the patient's condition, the ODG citation, and lack of information provided about the ingredients.

Fanatrex - unknown prescription (between 10/1/14 and 1/18/2015): 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 Anti-Epilepsy Drugs Page(s): 16-21.

Decision rationale: Fanatrex is stated to be a formulation of gabapentin. The treating physician has stated that it is for neuropathic pain. None of the physician reports adequately discuss the signs and symptoms diagnostic of neuropathic pain. There are no physician reports which adequately address the specific symptomatic and functional benefit from the AEDs used to date. Note the criteria for a good response per the MTUS. The request does not contain a quantity, directions, or duration. Gabapentin is not medically necessary based on the lack of any clear indication, the lack of counseling and consent regarding the reproductive risks, and the lack of significant symptomatic and functional benefit from its use to date.

Synapryn unknown prescription (between 10/1/14 and 1/18/2015): 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 Opioids; Glucosamine (and Chondroitin Sulfate) Page(s): 77-80; 50.

Decision rationale: Synapryn is tramadol with glucosamine in an oral suspension: The reason for combining these medications is not discussed in any physician report. Given that tramadol is generally a prn medication to be used as little as possible, and that glucosamine (assuming a valid indication) is to be taken regularly regardless of acute symptoms, the combination product is illogical and not indicated. Tramadol is prescribed without clear evidence of the considerations and expectations found in the MTUS and similar guidelines. Opioids are minimally indicated, if at all, for chronic back pain. The prescribing physician does not specifically address function with respect to prescribing opioids, and does not address the other recommendations in the MTUS. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient has failed a trial of non-opioid analgesics. The MTUS provides support for treating moderate arthritis pain, particularly knee OA, with glucosamine sulphate. Other forms of glucosamine are not supported by good medical evidence. The treating physician in this case has not provided evidence of the form of glucosamine in Synapryn, and that it is the form recommended in the MTUS and supported by the best medical evidence. And should there

be any indication for glucosamine in this case, it must be given as a single agent apart from other analgesics, particularly analgesics like tramadol which are habituating. The request does not contain a quantity, directions, or duration. Synapryn is not medically necessary based on the MTUS, lack of good medical evidence, and lack of a treatment plan for chronic opioid therapy consistent with the MTUS.

Tabradol - unknown prescription (between 10/1/14 and 1/18/2015): 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 Muscle relaxants Page(s): 63.

Decision rationale: The request does not contain a quantity, directions, or duration. Tabradol is cyclobenzaprine in an oral suspension. The MTUS for Chronic Pain does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short term exacerbations of chronic low back pain. This patient has chronic pain with no evidence of prescribing for flare-ups, and the pain is in the extremity, not the low back. The MTUS states that treatment with cyclobenzaprine should be brief, and that the addition of cyclobenzaprine to other agents is not recommended. In this case, cyclobenzaprine is added to other agents, and the oral suspension form plus topical is experimental and unproven. Prescribing was not for a short term exacerbation. Multiple medications, including a topical muscle relaxant, were prescribed together without adequate trials of each. Per the MTUS, cyclobenzaprine is not indicated and is not medically necessary.

Cyclobenzaprine topical gel - unknown prescription (between 10/1/14 and 1/18/2015): Upheld

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

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

Decision rationale: The request does not contain a quantity, directions, or duration. Per the MTUS citation above, there is no good evidence in support of topical muscle relaxants; these agents are not recommended. In addition, two muscle relaxants were dispensed simultaneously (two forms of cyclobenzaprine), which is duplicative, unnecessary, and potentially toxic. This topical agent is not medically necessary based on the MTUS.

Ketoprofen cream - unknown prescription (between 10/1/14 and 1/18/2015): Upheld

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

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

Decision rationale: The request does not contain a quantity, directions, or duration. Note that topical ketoprofen is not FDA approved, and is not recommended per the MTUS citation above. This topical agent is not medically necessary based on the MTUS.