

Case Number:	CM14-0209046		
Date Assigned:	02/03/2015	Date of Injury:	07/17/2011
Decision Date:	03/03/2015	UR Denial Date:	11/13/2014
Priority:	Standard	Application Received:	12/15/2014

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: Pennsylvania
 Certification(s)/Specialty: Internal 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 51 year old female with a date of injury of 7/17/11. The injured worker was pulling on a suitcase with force and heard a snap in her back and felt immediate shooting pain in the back. Diagnoses include lumbago, lumbar spine sprain/strain, lumbar radiculopathy, pain and discomfort in bladder area, and proctalgia. Medical history includes leukemia, anemia, hysterectomy gastroesophageal reflux disease (GERD) and stomach and bladder surgery. Treatment included physical therapy and medications. Initial comprehensive primary treating physician report of 9/18/14 noted the initial injury as well as cumulative trauma from July 18, 2011 to March 2012 as a result of which back pain progressively worsened. The injured worker reported burning radicular low back pain and muscle spasms, and stated that pain was alleviated with medications, rest, and activity restrictions. The current medications were not noted. Work status was noted as full duty with no restrictions or limitations. Medications were prescribed and the physician documented a plan to monitor for effectiveness and possible dependency as well as a plan for periodic urine toxicology evaluation. Physical therapy note of 9/29/14 notes that previous treatment included physical therapy, TENS (transcutaneous electrical stimulation), heat, and exercises. Medications were listed as flexeril, tramadol, and norco. Physical therapy log notes visit dates of 9/29/14, 10/7/14, 10/9/14 and 10/14/14. The PR2 of 10/16/14 noted the injured worker continued to complain of burning radicular low back pain and muscle spasms, with the pain rated as 7/10 and described as constant, traveling down both legs and associated with numbness and tingling. She reported that medications offer her temporary relief of pain and improve her ability to have restful sleep. Examination showed tenderness at the lumbar

paraspinal musculature with trigger points, decreased range of motion, decreased sensation at the L5 and S1 dermatomes bilaterally, decreased motor strength in the bilateral lower extremities secondary to pain, and normal reflexes. Examination of the abdomen was not noted. As of the 10/16/14 visit, work status was full duty with no limitations or restrictions. Magnetic resonance imaging of the lumbar spine on 11/4/14 showed broad based disc herniations abutting the thecal sac with associated stenosis of the spinal canal at L3-4, L4-5 and L5-S1. On 11/13/14, Utilization review non-certified requests for urine toxicology screen, deprizine, dicopanol, fanatrex, synapryn, trabadol, cyclobenzaprine, ketoprofen cream, lumbar pillow, TENS unit, hot/cold therapy unit, physical therapy to the lumbar spine quantity 18, shockwave therapy for cervical, thoracic and lumbar spine quantity 6, functional capacity evaluation, referral to a urologist for consultation, referral to a proctologist for consultation, and terocin patches, citing the MTUS and ODG.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urine toxicology screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43, 76 - 77.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing, Opioids Page(s): 43,77-78, 89, 94. Decision based on Non-MTUS Citation Chronic pain chapter: urine drug testing

Decision rationale: Per MTUS chronic pain medical treatment guidelines, urine drug screens are recommended as an option to assess for the use or the presence of illegal drugs, in accordance with a treatment plan for use of opioid medication, and as a part of a pain treatment agreement for opioids. Per the ODG, urine drug testing is recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. Urine drug testing is recommended at the onset of treatment when chronic opioid management is considered, if the patient is considered to be at risk on addiction screening, or if aberrant behavior or misuse is suspected or detected. Ongoing monitoring is recommended if a patient has evidence of high risk of addiction and with certain clinical circumstances. Frequency of urine drug testing should be based on risk stratification. Patients with low risk of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. Patients at moderate risk for addiction/aberrant behavior should be tested 2-3 times per year. Patients at high risk of adverse outcomes may require testing as often as once a month. Random collection is recommended. Results of testing should be documented and addressed. Although the physical therapy note from September 2014 noted that medications included tramadol and norco, the current medications were not documented in the physician progress notes provided. Although the physician documented a plan to monitor for effectiveness and possible dependency as well as a plan for periodic urine toxicology evaluation, there was no risk assessment for aberrant behavior documented, and no previous urine drug screens were provided or discussed. The documentation included a request for synapryn, which contains

tramadol, however the medical necessity of this medication has not been established. For these reasons, the request for urine drug screen is not medically necessary.

Deprizine (dosage and quantity unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 50.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms and cardiovascular risk Page(s): 68-69.

Decision rationale: Deprizine contains ranitidine, a histamine-2 blocker which is used to decrease the production of stomach acid. The documentation indicates that the injured worker had a history of GERD, but no current gastrointestinal symptoms were noted, and no abdominal examination was described. The MTUS addresses risk of gastrointestinal side effects from nonsteroidal anti-inflammatory agents (NSAIDS), however there was no documentation that this injured worker was using NSAID medication. The requested prescription is for an unstated quantity, and the medical records do not clearly establish the quantity. Requests for unspecified quantities of medications are not medically necessary, as the quantity may potentially be excessive and in use for longer than recommended. The request for deprizine, dosage and quantity unspecified, is not medically necessary.

Dicopanol (dosage and quantity unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 17, 20, 22, 24, 26, 50, and 68.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic pain chapter: insomnia treatment

Decision rationale: Dicopanol contains diphenhydramine, a histamine blocker used in the treatment of allergies and as a sleep aide. The documentation notes the injured reported that medications offer her temporary relief of pain and improve her ability to have restful sleep, however the medications used for this reason were not specified. The ODG recommends that pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. No specific sleep disturbance or evaluation of sleep disturbance was discussed in the records provided. The requested prescription is for an unstated quantity, and the medical records do not clearly establish the quantity. Requests for unspecified quantities of medications are not medically necessary, as the quantity may potentially be excessive and in use for longer than recommended. The request for Dicopanol (dosage and quantity unspecified) is not medically necessary.

Fanatrex (dosage and quantity unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 17, 20, 22, 24, 26, 50, and 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines gabapentin Page(s): 49.

Decision rationale: Fanatrex contains gabapentin, an anti-epilepsy drug which has been shown to be effective for treatment of diabetic neuropathy and postherpetic neuralgia and has been considered as a first line treatment for neuropathic pain. It is recommended for some neuropathic conditions and fibromyalgia. The injured worker does have a diagnosis of lumbar radiculopathy. However, the requested prescription is for an unstated quantity, and the medical records do not clearly establish the quantity. Requests for unspecified quantities of medications are not medically necessary, as the quantity may potentially be excessive and in use for longer than recommended. The request for Fanatrex (dosage and quantity unspecified) is not medically necessary.

Synapryn (dosage and quantity unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 17, 20, 22, 24, 26, 50, and 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines glucosamine and chondroitin; opioids Page(s): 50, 74-96. Decision based on Non-MTUS Citation Pain chapter: compounded drugs

Decision rationale: Synapryn contains glucosamine and tramadol. Glucosamine is recommended as an option in patients with moderate arthritis pain, especially for knee osteoarthritis. There is no documentation that the injured worker has a diagnosis of arthritis. Tramadol is a synthetic opioid. The MTUS recommends trying one medication at a time when opioids are prescribed. An adequate medication history for this injured worker was not documented, and the current medications are not clearly specified in the records provided. The ODG notes that compounded drugs are not recommended as a first-line therapy. The requested prescription is for an unstated quantity, and the medical records do not clearly establish the quantity. Requests for unspecified quantities of medications are not medically necessary, as the quantity may potentially be excessive and in use for longer than recommended. The request for Synapryn (dosage and quantity unspecified) is not medically necessary.

Tabradol (dosage and quantity unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 17, 20, 22, 24, 26, 50, and 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63-66. Decision based on Non-MTUS Citation Pain chapter: compounded drugs

Decision rationale: Trabadol contains cyclobenzaprine, a muscle relaxant, and methylsulfonylmethane (MSM). Nonsedating 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. The greatest effect of treatment with cyclobenzaprine is in the first four days of treatment. The documentation indicates the injured worker has chronic low back pain; acute exacerbation was not documented. In addition, the requested treatments also include a separate request for cyclobenzaprine, which is duplicative and potentially toxic. MSM is a dietary supplement which is sometimes used in the treatment of arthritic pain. The documentation does not indicate that the injured worker has a diagnosis of arthritis. The ODG notes that compounded drugs are not recommended as a first-line therapy. The requested prescription is for an unstated quantity, and the medical records do not clearly establish the quantity. Requests for unspecified quantities of medications are not medically necessary, as the quantity may potentially be excessive and in use for longer than recommended. The request for Tabradol (dosage and quantity unspecified) is not medically necessary.

Cyclobenzaprine (dosage and quantity unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63 - 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63-66.

Decision rationale: Cyclobenzaprine is a muscle relaxant and central nervous system depressant. Nonsedating 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. The greatest effect of treatment with cyclobenzaprine is in the first four days of treatment. The documentation indicates the injured worker has chronic low back pain; acute exacerbation was not documented. The MTUS notes that sedative effects of cyclobenzaprine may limit use. In addition, the requested treatments also include a separate request for trabadol, which contains cyclobenzaprine, making the request duplicative and potentially toxic. The requested prescription is for an unstated quantity, and the medical records do not clearly establish the quantity. Requests for unspecified quantities of medications are not medically necessary, as the quantity may potentially be excessive and in use for longer than recommended. The request for cyclobenzaprine, dosage and quantity not specified, is not medically necessary.

Ketoprofen cream (dosage and quantity unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section Page(s): 111 - 113.

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

Decision rationale: Ketoprofen is a nonsteroidal anti-inflammatory agent (NSAID). Ketoprofen is not currently FDA approved for topical application. It has a high incidence of photocontact dermatitis. There is little evidence to utilize topical NSAIDS for treatment of osteoarthritis of the spine, hip, or shoulder, and topical NSAIDS are not recommended for neuropathic pain. There is

no documentation that the injured worker has a diagnosis of arthritis. The requested prescription is for an unstated quantity, and the medical records do not clearly establish the quantity. Requests for unspecified quantities of medications are not medically necessary, as the quantity may potentially be excessive and in use for longer than recommended. The request for Ketoprofen cream (dosage and quantity unspecified) is not medically necessary.

Lumbar pillow: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2007 Update), Chapter 12), pages 76 - 77

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: Per the MTUS, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The documentation indicates the injured worker has chronic low back pain. The goal of treatment for chronic pain is functional improvement, rather than elimination of pain. The work status has been documented as full duty without restrictions, indicating a high level of function. The request for lumbar pillow is not medically necessary.

TENS unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114 - 116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: TENS , or transcutaneous electrical nerve stimulation, is not recommended as a primary treatment modality, but a one month home based TENS trial may be considered as an option if used as an adjunct to a program of evidence-based functional restoration for treatment of neuropathic pain and complex regional pain syndrome. Criteria for use include documentation of pain of at least three months duration, evidence that other appropriate pain modalities, including medication, have been tried and failed, and documentation of a treatment plan including the specific short and long term goals of treatment with the TENS unit. There was no documentation of failure of other modalities including medication, and the submitted documentation did not include a treatment plan discussing specific short and long term goals of treatment with the TENS unit. The duration of use of the unit was also not specified. The request for TENS unit is not medically necessary.

Hot/cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299, table 12-5.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299.

Decision rationale: Per the ACOEM low back chapter, at-home applications of heat or cold may be used for symptom control for low back complaints. Per the ODG, heat therapy is recommended as an option for treating low back pain. Both the MTUS and ODG recommend at-home local applications of cold packs in the first few days of acute complaint and thereafter applications of heat packs or cold packs. There was lack of documentation to indicate the frequency of use of the device, and no end point to use was specified. In addition, there was no documentation as to why at-home application of hot or cold packs would be insufficient. For these reasons, the request for hot/cold therapy unit is not medically necessary.

Eighteen sessions of physical therapy for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Section Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical Therapy Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99.

Decision rationale: Per the MTUS, functional improvement is the goal in the treatment of chronic pain, rather than the elimination of pain. The maximum recommended quantity of physical medicine visits is 10, with progression to home exercise program. The treating physician has not stated a purpose for the current physical therapy prescription. The number of sessions requested (18) greatly exceeds the quantity recommended in the MTUS. The treating physician has not provided reasons why the injured worker requires a course of physical therapy which is substantially longer than that recommended in the cited guidelines. The injured worker has already undergone recent physical therapy and treatment log documents four visits in September and October 2014. Per the MTUS, patients are expected to continue active therapies at home as an extension of the treatment process; the injured worker should be able to transition to a home exercise program. Functional status is now quite good as the treating physician notes a work status of full duty with no restrictions or limitations. As the number of sessions requested exceeds the quantity recommended by the MTUS and as the work status is noted as full duty without restrictions, the request for 18 sessions of physical therapy is not medically necessary.

Six sessions of shockwave therapy cor cervical, thoracic 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 (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation low back chapter

Decision rationale: Per the ODG, low back chapter, shock wave therapy is not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating low back pain. The documentation did not note any diagnoses referable to the cervical or thoracic spine. The injured worker had chronic low back pain with lumbar radiculopathy. The request for shock wave therapy for cervical, thoracic, and lumbar spine is not medically necessary.

Functional capacity evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Independent Medical Examinations and Consultations Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7), pages 137 - 138

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation fitness for duty chapter: functional capacity evaluation

Decision rationale: Per the ODG, functional capacity evaluation is recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. Functional capacity evaluation is not recommend for routine use as part of occupational rehab or screening, or generic assessments in which the question is whether someone can do any type of job generally. The documentation did not indicate that admission to a work hardening program was anticipated. The treating physician documented a work status of full duty without restrictions or limitations. The request for functional capacity evaluation is not medically necessary.

Referral for a urologist for consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Independent Medical Examinations and Consultations Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7), page 127

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation low back chapter: office visits

Decision rationale: The ODG recommends office visits as determined to be medically necessary. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The documentation notes a diagnosis of pain and discomfort in bladder area, and that the injured worker had a history of bladder surgery. The progress notes do not document any current bladder signs or symptoms, nor any initial evaluation for bladder issues such as laboratory testing/urinalysis. There was no abdominal or pelvic examination documented. Due to the lack of documentation of urologic signs or symptoms, the request for referral to a urologist for consultation is not medically necessary.