

Case Number:	CM15-0107956		
Date Assigned:	07/23/2015	Date of Injury:	01/22/2015
Decision Date:	09/17/2015	UR Denial Date:	05/27/2015
Priority:	Standard	Application Received:	06/04/2015

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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational 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 50 year old female who sustained an industrial injury on 01/22/2015. Current diagnoses include cervical spine pain, cervical spine radiculopathy, rule out cervical disc displacement herniated nucleus pulposus, left shoulder pain, rule out left shoulder rotator cuff tear, left wrist tenosynovitis, rule out left wrist internal derangement, low back pain, radiculitis-lower extremity, rule out lumbar disc displacement herniated nucleus pulposus, right hip sprain/strain, rule out right hip internal derangement, right knee pain, rule out right knee internal derangement, right ankle sprain/strain, and rule out right ankle internal derangement. Previous treatments included medications, acupuncture, shockwave therapy, and neurostimulation therapy. Initial injuries included the neck, left shoulder, left wrist, low back, right hip, right knee, right ankle, and abdomen after slipping and falling. Report dated 07/07/2015 noted that the injured worker presented with complaints that included burning radicular neck pain with spasms associated with numbness and tingling of the bilateral lower extremities, burning left shoulder pain with radiation to the arm and fingers associated with muscle spasms, burning left wrist pain and muscle spasms with associated weakness, numbness, tingling, and radiation to the hand and fingers, burning radicular low back pain and muscle spasms with associated numbness and tingling of the bilateral lower extremity, burning right hip pain and muscle spasms, burning right knee pain and muscle spasms with numbness and tingling radiating to the foot, and burning right ankle pain and muscle spasms. Pain level was 7 (neck, left shoulder, low back), 6 (left wrist, right ankle), and 4 (right hip, right knee) out of 10 on a visual analog scale (VAS). Cervical examination was positive for decreased range of motion,

tenderness at the suboccipital region as well as over both scalene and trapezius muscles, and positive special orthopedic testing. Left shoulder examination was positive for tenderness at the subacromial space and the supraspinatus and the AC joint, decreased range of motion, and positive supraspinatus test on the left. Left wrist examination revealed tenderness at the carpal tunnel and the first dorsal extensor muscle compartment and carpal bones and over the thenar and hypothenar eminences, decreased range of motion, and decreased strength in the left. Neurologic examination of the bilateral upper extremity revealed decreased sensation over the C6, C7 dermatomes in the left upper extremity, and decreased left upper extremity strength. Lumbar spine examination revealed an antalgic gait, pain with heel walking, tenderness at the lumbar paraspinal muscles, sacro-tuberous ligaments, spinous process, bilateral muscle guarding, decreased range of motion, and positive lumbosacral orthopedic testing bilaterally. Right hip examination revealed tenderness in the right greater trochanter, decreased range of motion, and positive orthopedic test on the right. Right knee examination revealed tenderness over the medial and lateral joint line, decreased range of motion, negative orthopedic tests,, and no ligament instability. Right ankle examination revealed tenderness over the medial malleolus and anterior talofibular ligament, decreased range of motion, and positive orthopedic testing in the right. Neurological examination of the bilateral lower extremity revealed decreased sensation at the L5 and S1 dermatomes bilaterally and decreased motor strength. The treatment plan included explaining medication usage, periodic UA toxicology evaluation will be performed, the injured worker is to undergo a course of physical therapy, continue acupuncture, continue shockwave therapy, pending functional capacity evaluation, continue localized intense neurostimulation, referred for pain management specialist consultation regarding epidural steroid injections for the cervical and lumbar spine and orthopedic surgeon co nsultation regarding the left shoulder, and Terocin patches for pain relief are requested by the injured worker. The primary treating physician noted that the injured workers work status is modified duty with restrictions and if unable to accommodate remain temporarily totally disabled. Disputed treatments include functional capacity evaluation, 3 shockwave therapy for left shoulder, left wrist, right hip, right knee and right ankle, 6 localized intense neurostimulation therapy for lumbar spine, 1 pain management consultation- cervical and lumbar spine, 1 orthopedic surgeon consultation-left shoulder, unknown prescription Terocin Patches, unknown prescription Synapryn 10mg, unknown prescription Tabradol 1mg, unknown prescription Deprizine 15mg, unknown prescription Dicopanol 5mg, unknown prescription Fanatrex 25mg, and 6 shockwave treatments for cervical and lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional capacity evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Fitness for Duty: Functional Capacity Evaluation (FCE).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 4-5, Chronic Pain Treatment Guidelines Work conditioning, work hardening Page(s): 125. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty/Functional capacity evaluation (FCE).

Decision rationale: The MTUS states that to determine fitness for duty, it is often necessary to "medically" gauge the capacity of the individual compared with the objective physical requirements of the job based on the safety and performance needs of the employer and expressed as essential functions. Per the ODG, Guidelines for performing an FCE: Recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. If a worker is actively participating in determining the suitability of a particular job, the FCE is more likely to be successful. A FCE is not as effective when the referral is less collaborative and more directive. It is important to provide as much detail as possible about the potential job to the assessor. Job specific FCEs are more helpful than general assessments. The report should be accessible to all the return to work participants. Consider an FCE if: 1) Case management is hampered by complex issues such as: 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. 2) Timing is appropriate: Close or at MMI/all key medical reports secured. Additional/secondary conditions clarified. Do not proceed with an FCE if the sole purpose is to determine a worker's effort or compliance. The worker has returned to work and an ergonomic assessment has not been arranged. A review of the injured workers medical records that are available to me do not describe a purpose or goal for the evaluation and without this it is difficult to establish medical necessity based on the guidelines. Therefore, the request for functional capacity evaluation is not medically necessary at this time.

3 Shockwave therapy for left shoulder, left wrist, right hip, right knee and right ankle:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 14 Ankle and Foot Complaints Page(s): 203, 371. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg (Acute and Chronic): Extracorporeal shock wave therapy (ESWT).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Extracorporeal shock wave therapy (ESWT), shoulder, knee, ankle and foot.

Decision rationale: The California MTUS or ACOEM guidelines do not address shockwave therapy for left shoulder, left wrist, right hip, right knee and right ankle. The Official Disability Guidelines (ODG) recommends Extracorporeal shock wave therapy (ESWT) for calcifying tendinitis but not for other shoulder disorders. ESWT for the knee is under study for patellar tendinopathy and for long-bone hypertrophic non-unions. In the first study of this therapy for management of chronic patellar tendinopathy, extracorporeal shockwave therapy seemed to be safer and more effective, with lower recurrence rates, than conventional conservative treatments, according to results of a recent small, randomized controlled trial. New research suggests that extracorporeal shock-wave therapy (ESWT) is a viable alternative to surgery for long-bone hypertrophic non-unions. However, the findings need to be verified, and different treatment protocols as well as treatment parameters should be investigated, including the number of shock waves used, the energy levels applied and the frequency of application. New data presented at

the American College of Sports Medicine Meeting suggest that extracorporeal shockwave therapy (ESWT) is ineffective for treating patellar tendinopathy, compared to the current standard of care emphasizing multimodal physical therapy focused on muscle retraining, joint mobilization, and patellar taping. ESWT for the ankle not recommended using high energy ESWT. Recommended using low energy ESWT as an option for chronic plantar fasciitis, where the latest studies show better outcomes without the need for anesthesia. Guidelines do not address ESWT for the wrist or ankle. The medical records submitted do not support that the injured worker has a diagnosis of calcifying tendinitis or patellar tendinopathy, plantar fasciitis, or Achilles tendinitis. Therefore the request for 3 Shockwave therapy for left shoulder, left wrist, right hip, right knee and right ankle is not medically necessary.

6 Localized intense neurostimulation therapy for 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, Low Back-Lumbar & Thoracic (Acute and Chronic): Hyperstimulation analgesia.

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-lumbar & Thoracic, Hyperstimulation analgesia.

Decision rationale: The California MTUS and ACOEM guidelines do not address Localized intense neurostimulation therapy for lumbar spine. The Official Disability Guidelines do not recommend until there are higher quality studies. Initial results are promising, but only from two low quality studies sponsored by the manufacturer. Localized manual high-intensity neurostimulation devices are applied to small surface areas to stimulate peripheral nerve endings (A α fibers), thus causing the release of endogenous endorphins. This procedure, usually described as hyperstimulation analgesia, has been investigated in several controlled studies. However, such treatments are time consuming and cumbersome, and require previous knowledge of the localization of peripheral nerve endings responsible for LBP or manual impedance mapping of the back, and these limitations prevent their extensive utilization. The new device is capable of automatically measuring skin impedance in a selected body area and, immediately afterwards, of stimulating multiple points that are targeted according to differentiation in their electrical properties and proprietary image processing algorithms with high intensity yet non-painful electrical stimulation. The therapeutic neurostimulation pulse modulation of dense electrical pulses is applied locally to specific Active Trigger Points (ATPs) which are locations of nerve ending associated with pain, providing effective pain relief by stimulating the release of endorphins, the body's natural pain killers. The gate control theory of pain describes the modulation of sensory nerve impulses by inhibitory mechanisms in the central nervous system. One of the oldest methods of pain relief is generalized hyperstimulation analgesia produced by stimulating myofascial trigger points by dry needling, acupuncture, intense cold, intense heat, or chemical irritation of the skin. The moderate-to-intense sensory input of hyperstimulation analgesia is applied to sites over, or sometimes distant from, the pain. A brief painful stimulus may relieve chronic pain for long periods, sometimes permanently. The new device takes advantage of these same principles. Hyperstimulation analgesia with localized, intense, low-rate electrical pulses applied to painful active myofascial trigger points was found

to be effective in 95% patients with chronic nonspecific low back pain, in a clinical validation study. The results of this current pilot study show that treatment with this novel device produced a clinically significant reduction in back pain in almost all patients after four treatment sessions. The guidelines used to address this request do not recommend this type of treatment due to lack of supporting evidence. Therefore, the request for 6 Localized intense neurostimulation therapy for lumbar spine is not medically necessary.

1 Pain management consultation- cervical and lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic Pain Disorder Medical Treatment Guidelines, State of Colorado Department of Labor and Employment (Chapter: Chronic Pain Disorder; Section: Therapeutic Procedures, Non-Operative), page 56.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7: Independent Medical Examinations and Consultations, page 127.

Decision rationale: The California MTUS is silent. ACOEM (Independent Medical Examinations and Consultations Chapter) recommend occupational health practitioners may refer to other specialists if the diagnosis is uncertain, or when psychosocial factors are present. The medical records submitted for review indicate that the request for a Pain management consultation-cervical and lumbar spine is for possible epidural steroid injections. The treating physician did not provide a rationale for the request, there was no documentation of other failed conservative treatments to date. Therefore the request for 1 Pain management consultation- cervical and lumbar spine is not medically necessary.

1 Orthopedic surgeon consultation-left shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7: Independent Medical Examinations and Consultations, page 127.

Decision rationale: The California MTUS is silent. ACOEM (Independent Medical Examinations and Consultations Chapter) recommend occupational health practitioners may refer to other specialists if the diagnosis is uncertain, or when psychosocial factors are present. The submitted medical records support that the injured worker is having continued left shoulder pain, and the primary treating physician is concerned about a left shoulder rotator cuff tear. Left shoulder examination was positive for tenderness at the subacromial space and the supraspinatus and the acromioclavicular joint, decreased range of motion, and positive supraspinatus test on the left. Due to the abnormal findings on physical examination and continued pain the request for 1 Orthopedic surgeon consultation-left shoulder is medically necessary.

Unknown prescription Terocin Patches: Upheld

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

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

Decision rationale: According to the California MTUS Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, local anesthetics or antidepressants. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case there is no documentation provided necessitating Terocin. This medication contains methyl salicylate, capsaicin, menthol, and lidocaine. MTUS states that capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. There is no documentation of intolerance to other previous medications. Medical necessity for the requested topical medication has not been established. The request for Unknown prescription Terocin Patches is not medically necessary.

Unknown prescription Synapryn 10mg: 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 Glucosamine (and Chondroitin Sulfate), Opioid section Page(s): 50, 74-96.

Decision rationale: Synapryn 500ml (tramadol with glucosamine) 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 is to be taken regularly regardless of acute symptoms. Tramadol is prescribed without clear evidence of the considerations and expectations found in the MTUS and similar guidelines. 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. 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.

Unknown prescription Tabradol 1mg: 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 Cyclobenzaprine, Muscle relaxants for pain Page(s): 42, 63.

Decision rationale: 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. The MTUS states that treatment with cyclobenzaprine should be short-term. Prescribing was not for a short term exacerbation. Therefore, the request for Unknown prescription Tabradol 1mg is not medically necessary.

Unknown prescription Deprizine 15mg: 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 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. Ranitidine is not medically necessary based on the MTUS. Therefore, the request for Unknown prescription Deprizine 15mg is not medically necessary.

Unknown prescription Dicopanor 5mg: 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, 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. 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. Therefore, the request for Unknown prescription Dicopanol 5mg is not medically necessary.

Unknown prescription Fanatrex 25mg: 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-Gabapentin, Medications for chronic pain Page(s): 18-19, 60.

Decision rationale: Per the California MTUS chronic pain medical treatment guidelines recommend specific guidelines for the use of gabapentin. Gabapentin has been shown to be effective for the treatment of diabetic painful neuropathy and post-herpetic neuralgia and has been considered the first line treatment for neuropathic pain. 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. Gabapentin is not medically necessary based on the lack of any clear indication, the lack of counseling, and the lack of significant symptomatic and functional benefit from its use to date. Therefore the request for Unknown prescription Fanatrex 25mg is not medically necessary.

6 Shockwave treatments for cervical 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, Low Back-Lumbar and Thoracic (Acute and Chronic): Shock Wave Therapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic)/Extracorporeal shock wave therapy (ESWT).

Decision rationale: The MTUS/ACOEM did not sufficiently address the use of shockwave treatments for the cervical and lumbar spine therefore, other guidelines were consulted. Per the ODG, ECSWT is not recommended for back pain. The available evidence does not support the effectiveness of shock wave for treating back pain. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. A review of the injured workers medical records that are available to me do not reveal extenuating circumstances that would warrant deviating from the guidelines, therefore the request for 6 Shockwave treatments for cervical and lumbar spine is not medically necessary.