

Case Number:	CM15-0014942		
Date Assigned:	03/09/2015	Date of Injury:	05/15/2014
Decision Date:	04/21/2015	UR Denial Date:	01/15/2015
Priority:	Standard	Application Received:	01/26/2015

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: 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 46-year-old male who has reported knee pain after falling on 05/15/2014. Diagnoses include internal derangement and sprain of the knee. Treatment prior to 6/10/14 included Norco and knee radiographs. Per the initial evaluation report of 06/10/2014, the injured worker had ongoing knee pain with paresthesias and pain radiating to the foot. Medications were pain medications and medication for inflammation. There was pain, crepitation, and tenderness over the medial and lateral joint lines, decreased range of movement (130 flexion) and decreased motor strength secondary to pain. There were no neurological deficits. The treatment plan was for x-rays, transcutaneous electrical nerve stimulation (TENS) unit, Hot/cold, physical therapy and acupuncture for 18 visits, shockwave, functional capacity exam, electromyogram-nerve conduction velocity, Terocin patches, internal medicine referral and various other topical and oral medications. There were no patient-specific indications for any of the requests. The report included a list of medications with generic descriptions and indications. The work status was temporarily totally disabled. On 01/15/2015 Utilization Review non-certified a TENS Unit, a Hot/Cold Unit, physical therapy for the right knee, acupuncture for the right knee, shockwave therapy, a Functional Capacity Evaluation, an MRI of the right knee, EMG/NCS, Terocin patches, Ketoprofen 20% cream, Cyclobenzaprine 5% cream, Synapryn, Tabradol, Deprizine, Dicoprofanol, and Fanatrex. This determination was related to a request for authorization from 6/10/14. The MTUS and the Official Disability Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS Unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS for Chronic Pain Page(s): 114-117.

Decision rationale: No physician reports address the specific medical necessity for a TENS unit. The ACOEM Guidelines for treating acute knee pain state that there is insufficient evidence to support TENS for knee pain. The MTUS for Chronic Pain lists the indications for TENS, which are primarily neuropathic pain, a condition not present in this patient. Other recommendations, including specific components of the treatment plan, are listed in the MTUS. The necessary kind of treatment plan is not present, including a focus on functional restoration with a specific trial of TENS alone. Given the lack of clear indications in this injured worker (primary reason), and the lack of any clinical trial or treatment plan per the MTUS (secondary reason), a TENS unit is not medically necessary.

Hot/Cold Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 13 Knee Complaints Page(s): 48, 338. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Updated Chronic Pain Section, Heat and Cold Therapies, page 166, 168.

Decision rationale: The ACOEM Guidelines page 338 recommend cold packs during the first few days for knee pain, and heat packs thereafter. There is no recommendation for any specific device in order to accomplish this. Heat and cold can be applied to the skin using simple home materials, e.g. ice and hot water, without any formal medical device or equipment. The updated ACOEM Guidelines for Chronic Pain are also cited. There may be some indication for heat or cold therapy, but the recommendation is for home application of non-proprietary, low-tech, therapy in the context of functional restoration. There is no evidence of any current functional restoration program, particularly because the work status is temporarily totally disabled. The treating physician has not provided any information in support of the specific devices prescribed for this patient, and the nature of the requested device was not explained. The cold-heat device prescribed for this injured worker is not medically necessary based on the MTUS, other guidelines, and lack of a sufficient treatment plan.

Physical Therapy for the Right Knee: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337-338. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) knee-leg chapter: physical medicine treatment.

Decision rationale: The physical therapy in question was prescribed during the acute injury phase. The ACOEM Guidelines portion of the MTUS is the applicable section for determining medical necessity. The ACOEM Guidelines pages 337-338, knee; recommend a few visits with a physical therapist for instructions in self-care and exercise. After a few physical therapy visits, patients should be able to exercise and perform self-care independently. Another evidence-based guideline, the Official Disability Guidelines, recommends a maximum of 9 physical therapy visits. The Official Disability Guidelines also recommend that 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). The progress note documents that 18 visits of physical therapy were prescribed. The current prescription for 18 visits significantly exceeds the quantity recommended in the MTUS (1-2 visits), and in the Official Disability Guidelines (a 6 visit trial, up to 9 visits maximum). The actual request to Independent Medical Review is for an unspecified number of visits, which is also potentially greatly in excess of guideline recommendations. The requested physical therapy is not medically necessary based on an insufficient request to IMR, and an 18-visit recommendation in the reports that exceeds guideline recommendations.

Acupuncture for the Right Knee: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The prescription for acupuncture is evaluated in light of the MTUS recommendations for acupuncture. Per the MTUS, acupuncture is 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. The treating physician has not provided the specific indications for acupuncture as listed in the MTUS. An initial course of acupuncture is 3-6 visits per the MTUS. The records refer to 18 visits, which exceeds the quantity recommended in the MTUS. The Independent Medical Review request does not list a total quantity of visits. Open-ended prescriptions for acupuncture are not medically necessary, as the MTUS recommendations for acupuncture are very specific regarding quantity of visits, duration of treatment, and measures of outcome. An initial course of acupuncture is not medically necessary based on a prescription, which exceeds the quantity recommended in the MTUS, and lack of specific indications per the MTUS.

Shockwave Therapy: 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), Treatment Index, 12th Edition (web), 2015, Knee and Leg Chapter, 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) Knee chapter, Extracorporeal shock wave therapy (ESWT).

Decision rationale: The Official Disability Guidelines states that shockwave therapy for the knee is under study for patellar tendinopathy and long-bone hypertrophic nonunions. Neither of these conditions is present in this injured worker. Shockwave therapy for the knee is not addressed in the MTUS. Per the cited guideline, shockwave therapy for the knee is not medically necessary.

Functional Capacity Evaluations: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Occupational Medical Practice Guidelines, Second Edition (2004), Chapter 7, page 511.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 137-8, Chronic Pain Treatment Guidelines Work Conditioning, Work Hardening Page(s): 126. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty chapter, Functional capacity evaluation.

Decision rationale: The ACOEM guidelines pages 137-8, in the section referring to Independent Medical Evaluations (which is not the context in this case), state there is little scientific evidence confirming that functional capacity evaluations predict an individual's actual capacity to perform in the workplace and it is problematic to rely solely upon the functional capacity evaluation results for determination of current work capability and restrictions. The MTUS for Chronic Pain and the Official Disability Guidelines recommend a functional capacity evaluation for Work Hardening programs, which is not the context in this case. The Official Disability Guidelines state that a 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. Not recommend 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 current request does not meet this recommendation, as it appears to be intended for general rather than job-specific use. The treating physician has not defined the components of the functional capacity evaluation. Given that there is no formal definition of a functional capacity evaluation, and that a functional capacity evaluation might refer to a vast array of tests and procedures, medical necessity for a functional capacity evaluation (assuming that any exists), cannot be determined without a specific prescription, which includes a description of the intended content of the evaluation. The MTUS for Chronic Pain, in the Work Conditioning-Work Hardening section, mentions a functional capacity evaluation as a possible criterion for entry, based on specific job demands. The treating physician has not provided any information in compliance with this

portion of the MTUS. The functional capacity evaluation in this case is not medically necessary based on lack of medical necessity and lack of a sufficiently specific prescription.

MRI of the Right Knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 332-335, 341, 343, 344-345, 347.

Decision rationale: Per the ACOEM Guidelines Page 341, special studies are not needed to evaluate most knee conditions until after a period of conservative care and observation. Page 343 lists surgical indications: activity limitation for more than one month, failure of an exercise program. Pages 344-5 discuss focal pathology amenable to surgery. Page 347 lists the clinical findings, which indicate the need for surgery. In this case the question would be whether there is a realistic possibility of significant intra-articular pathology and need for surgery after a failure of conservative care. The available reports do not adequately explain the kinds of conservative care already performed or the specific findings suggestive of surgical pathology. The listed findings are non-specific. The necessary components of the knee exam are not present, see pages 332-335 of the ACOEM Guidelines. There is no evidence of a sufficient period of conservative care prior to prescribing the MRI, and the necessary components of the examination are not provided. The MRI is not medically necessary based on the MTUS and lack of specific indications.

EMG/NCS: 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), Treatment Index, 12th Edition (web), 2015, Pain Chapter, Electrodiagnostic Testing (EMG/NCS).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343, 347.

Decision rationale: There are no reports from the prescribing physician, which adequately describe neurologic findings that necessitate electrodiagnostic testing. Non-specific pain or paresthesias are not an adequate basis for performance of EMG or NCV. Medical necessity for electrodiagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. Non-specific, non-dermatomal extremity symptoms are not sufficient alone to justify electrodiagnostic testing. Based on the available clinical information, there are no neurologic abnormalities and no specific neurologic symptoms. The MTUS, per the citations listed above, outlines specific indications for electrodiagnostic testing, and these indications are based on specific clinical findings. The physician should provide a diagnosis that is likely based on clinical findings, and reasons why the test is needed. The clinical evaluation is minimal and there is no specific neurological information showing the need for electrodiagnostic testing. The MTUS states that electrodiagnostic testing is not needed

for practically all the usual knee diagnoses. The specific indications in this case were not discussed by the physician. Based on the current clinical information, electrodiagnostic testing is not medically necessary, as the treating physician has not provided the specific indications and clinical examination outlined in the MTUS.

Terocin Patches: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, Topical Analgesics Page(s): 60, 111-113. Decision based on Non-MTUS Citation UpToDate: Camphor and Menthol: Drug Information.

Decision rationale: Per the MTUS, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. If any compounded product contains at least one drug or drug class that is not recommended, the compounded product is not recommended. Terocin patch contains lidocaine and menthol. The site of application and directions for use were not specified. Lidocaine is only FDA approved for treating post-herpetic neuralgia, and the dermal patch form (Lidoderm) is the only form indicated for neuropathic pain. There is no documentation that this injured worker has neuropathic pain or post-herpetic neuralgia. The MTUS and ODG are silent with regard to menthol. It may be used for relief of dry, itchy skin. This agent carries warnings that it may cause serious burns. Due to lack of indication, the request for Terocin patches is not medically necessary.

Ketoprofen 20% Cream, 165-grams: Upheld

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

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

Decision rationale: Ketoprofen, a nonsteroidal anti-inflammatory agent (NSAID), 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. As topical ketoprofen is not FDA approved, it is therefore experimental and cannot be presumed as safe and efficacious. Non-FDA approved medications are not medically necessary. As such, the request for ketoprofen cream is not medically necessary.

Cyclobenzaprine 5% Cream 100-grams: Upheld

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

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

Decision rationale: 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.

Synapryn 10mg/ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 13th Edition (web), 2015, Pain Chapter, Compound Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate), Opioids Page(s): 50, 77-80.

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 osteoarthritis, 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. The treating physician did not provide evidence for knee osteoarthritis. In addition, 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. 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 1mg/ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 12th Edition (web), 2015, Pain Chapter, Compound Drugs.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338, Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: Tabradol is cyclobenzaprine, a muscle relaxant, in an oral suspension. 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. Multiple medications, including a topical muscle relaxant, were prescribed together without adequate trials of each. The injured worker has an acute knee sprain. There was no documentation of muscle spasm. The ACOEM knee chapter recommends nonsteroidal anti-inflammatory agents for initial symptom control of knee complaints. There is no discussion of use of muscle relaxants for acute knee complaints. Per the MTUS, cyclobenzaprine is not indicated and is not medically necessary.

Deprizine 15mg/ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 13th Edition (web), 2015, Pain Chapter, Compound Drugs.

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. The prescribed medications included a request for a topical nonsteroidal cream. If ranitidine is prescribed as co therapy with an NSAID, ranitidine is not the best drug. Note the MTUS recommendations cited. There are no medical reports which describe signs and symptoms of possible GI disease. There is no examination of the abdomen on record. Co therapy 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.

Dicopanor 5mg/ml: 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), Treatment Index, 13th Edition (web), 2015, Pain Chapter, Compound Drugs, Insomnia Treatment.

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, the reason for prescription for Dicopanor was not stated. In some cases, diphenhydramine is used for the treatment of 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. Dicopanor 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.