

Case Number:	CM15-0144696		
Date Assigned:	08/06/2015	Date of Injury:	12/03/2013
Decision Date:	09/16/2015	UR Denial Date:	07/09/2015
Priority:	Standard	Application Received:	07/27/2015

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: New York

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 33 year old male, who sustained an industrial injury on 12-3-13. He reported an injury to low back, neck, shoulders and legs following a fall from a ladder. The injured worker was diagnosed as having jaw pain, rule out cervical disc displacement, cervical radiculopathy, sprain of ribs, left shoulder pain, sprain of left elbow, long finger injury-rule out internal derangement, sprain-strain of thoracic spine, rule out intervertebral disc displacement of thoracic region, lumbar radiculopathy, sprain-strain of bilateral hips, sprain of left knee-rule out internal derangement of left knee and disorder of left ankle ligament. Treatment to date has included Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclobenzaprine and Ketoprofen cream, Terocin patches, shockwave therapy, pain management and activity restrictions. (MRI) magnetic resonance imaging of left shoulder performed on 11-9-14 revealed tendinosis of supraspinatus, infraspinatus, subscapularis and biceps; osteoarthritis of acromioclavicular joint, subcortical cysts and subacromial-sub deltoid bursitis. (MRI) magnetic resonance imaging of left TMJ performed on 11-9-14 revealed anterior displacement of the articular disc with reduction to normal position with mouth opening and poor anterior translation of the mandibular condyle with jaw opening and right TMJ revealed poor anterior translation of the mandibular condyle with jaw opening. (MRI) magnetic resonance imaging of left knee performed on 3-29-14 revealed a small early osteochondral lesion, lateral femoral condyle. Currently on 4-23-15, the injured worker complains of jaw pain with radicular neck pain, burning and muscle spasms rated 6 out of 10 and described as moderate to severe; burning left shoulder pain radiating down the arm to fingers associated with muscle spasms rated 6 out of 10 and described as constant moderate to severe; dull achy left elbow pan and muscle spasms rated 7 out of 10 and described as frequent to

constant, moderate to severe. The injured worker also complains of sharp, stabbing left long finger pain associated with locking and clicking, rated 4 out of 10 and described as intermittent to constant, mild to moderate; dull, achy left rib pain rated 5 out of 10 and described as frequent to constant, mild to moderate; dull, achy often sharp, stabbing mid back pain and muscle spasms rated 9 out of 10 and described as constant, moderate to severe and sharp, stabbing low back pain and muscle spasms rated 9 out of 10 and described as frequent to constant, moderate to severe. He also complains of dull, achy, bilateral hip pain and muscle spasms rated 8 out of 10 on right and 4 out of 10 on left; burning left knee pain and muscle spasms rated 5-6 out of 10 and burning left ankle pain and spasms rated 4-5 out of 10. Physical exam performed on 4-23-15 revealed tenderness at the scalene, splenius and sternocleidomastoid muscles with trigger points noted at the bilateral upper trapezius and rhomboid muscles with decreased range of motion of cervical spine, tenderness to palpation of left 3rd through 6th ribs; tenderness to palpation at the trapezius and levator scapula and rhomboid muscles on left shoulder exam; left elbow exam revealed palpable tenderness over the medial and lateral epicondyle with restricted range of motion; tenderness at A1 pulley of left long finger and at head of the metacarpal as well as distal and proximal interphalangeal joint; tenderness at the spinous processes T3 to T8 with paraspinal muscle guarding and restricted range of motion; left knee exam revealed tenderness to palpation over the medial and lateral joint line to the patellofemoral joint with restricted range of motion and tenderness was noted to palpation over the medial and lateral malleolus of the left ankle with tenderness at the anterior talofibular ligament and posterior tibial tendon with slightly decreased range of motion. The treatment plan included request for Terocin patches, (MRI) magnetic resonance imaging of cervical spine, left elbow, thoracic spine, lumbar spine and bilateral hips, functional capacity evaluation, (EMG) Electromyogram of bilateral upper and lower extremities, shockwave therapy and continuation of Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclobenzaprine and Ketoprofen cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Deprizine (unknown prescription): 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 non-steroidal anti-inflammatory drugs (NSAIDs) gastrointestinal symptoms and cardiovascular risks Page(s): 68-69.

Decision rationale: Deprizine is ranitidine in an oral suspension. Ranitidine is prescribed without any rationale provided. There are no medical reports which adequately describe the relevant signs and symptoms of possible gastrointestinal (GI) disease. 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. 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.

Dicopanol (unknown prescription): 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 Treatment.

Decision rationale: Dicopanol 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. Dicopanol is not medically necessary on this basis alone. In addition, Dicopanol 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. 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.

Fanatrex (unknown prescription): 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): 16-18.

Decision rationale: Fanatrex is stated to be a formulation of gabapentin. 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. Gabapentin is not medically necessary based on the lack of any clear indication and the lack of significant symptomatic and functional benefit from its use to date.

Synapryn (unknown prescription): 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 Page(s): 74-96, 50.

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 medication to be used as little as possible, and that glucosamine 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. 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): 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: 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 located in multiple areas. 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, the oral suspension form plus topical is experimental and unproven. Prescribing was not for a short term exacerbation. Per the MTUS, cyclobenzaprine is not indicated and is not medically necessary.

Cyclobenzaprine (unknown prescription): Upheld

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

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

Decision rationale: No physician reports discuss the specific indications and medical evidence in support of the topical medications prescribed in this case. Medications are to be given individually, one at a time, with assessment of specific benefit for each medication. Provision of multiple medications simultaneously is not recommended. In addition to any other reason for lack of medical necessity for this topical agent, it is not medically necessary on this basis at minimum. The injured worker has received this medication since at least 10-14. The MTUS states that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Furthermore, the request does not indicate a dosage for the medication. Topical muscle relaxants are not recommended per the MTUS.

Ketoprofen cream (unknown prescription): Upheld

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

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

Decision rationale: The CA MTUS Chronic Pain Guidelines indicate that topical analgesics are "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." They are "largely experimental in use with few randomized controlled trials to determine effectiveness or safety." Ketoprofen is a non-steroidal anti-inflammatory drug (NSAID). The MTUS indicates that topical NSAIDs may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. Ketoprofen is not FDA approved for topical application. Non-FDA approved medications are not medically necessary. The only FDA-approved topical NSAIDs are Diclofenac formulations. All other topical NSAIDs are not FDA approved. The guidelines indicate that "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Therefore, the request for Ketoprofen cream is not medically necessary.

MRI cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guideline (ODG), Neck & Upper Back (Acute & Chronic), Magnetic Resonance Imaging (MRI) (2014).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (MRI) magnetic resonance imaging, neck and upper back.

Decision rationale: Per CA MTUS, ACOEM guidelines, "For most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. Criteria for ordering imaging studies are emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery and clarification of the anatomy prior to an invasive procedure. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminate imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures)." Per ODG guidelines, (MRI) magnetic resonance imaging of the neck is recommended only for "chronic neck pain with normal radiographs and neurologic signs or symptoms; neck pain with radiculopathy if severe or progressive neurologic deficit, chronic neck pain with radiographs showing spondylosis and neurologic signs or symptoms present, chronic neck pain with radiographs showing old trauma and neurologic signs or symptoms present, chronic neck pain with radiographs showing bone or disc margin destruction, suspected cervical spine trauma and equivocal or positive plain films with neurological deficit and upper back-thoracic spine trauma with neurological deficit". In this case, the injured worker had a (MRI) magnetic resonance imaging of cervical spine performed on 2-17-2014. As per progress notes in the Medical Records, the injured worker does not appear to have significant changes in symptoms and signs, no documentation of concerning changes in the neurological exam, and there are no red flags. Without such evidence and based on guidelines cited, the request for repeat MRI of the cervical spine is not medically necessary and appropriate.

MRI thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177 and 178. Char Format

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

Decision rationale: Per CA MTUS, ACOEM guidelines, "For most patients presenting with true neck or upper back problems, special studies are not needed unless a three or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. Criteria for ordering imaging studies are emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery and clarification of the anatomy prior to an invasive procedure. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminate imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures)." As per progress notes in the Medical Records, the injured worker does not appear to have significant changes in symptoms and signs, no documentation of concerning changes in the neurological exam, and there are no red flags. The injured worker had a (MRI) magnetic resonance imaging of thoracic spine performed on 2-17-2014. Without such evidence and based on guidelines cited, the request for repeat MRI of the thoracic spine is not medically necessary and appropriate.

MRI lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 53.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (MRI) magnetic resonance imaging, lumbar spine.

Decision rationale: As per Official Disability Guidelines (ODG); MRI (magnetic resonance imaging) is indicated for Lumbar spine trauma, neurological deficit, Thoracic spine trauma: with neurological deficit, Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit), Uncomplicated low back pain, suspicion of cancer, infection, other "red flags". Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit, Uncomplicated low back pain, prior lumbar surgery, Uncomplicated low back pain, cauda equina syndrome, Myelopathy (neurological deficit related to the spinal cord), traumatic Myelopathy, painful Myelopathy, sudden onset, Myelopathy, stepwise progressive, Myelopathy, slowly progressive, Myelopathy, infectious disease patient, Myelopathy, oncology patient. Repeat MRI: When there is significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). As per progress notes in the Medical Records, the injured worker does not appear to have significant changes in symptoms and signs, no documentation of concerning changes in the neurological exam, and

there are no red flags. Without such evidence and based on guidelines cited, the request for repeat MRI of the Lumbar spine is not medically necessary and appropriate.

MRI left elbow: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (Acute & Chronic), MRI's (2015).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow Chapter.

Decision rationale: Per ODG, (MRI) magnetic resonance imaging of the elbow is recommended only for chronic elbow pain with suspected intra-articular osteocartilaginous body, suspected occult injury, suspected unstable osteochondral injury, suspected nerve entrapment or mass, suspected chronic epicondylitis, suspected collateral ligament tear or suspected biceps tendon tear or bursitis when plain films are non-diagnostic. (MRI) magnetic resonance imaging of the elbow may provide important diagnostic information for evaluating the adult elbow in different conditions including: collateral ligament injury, epicondylitis, injury to biceps and triceps tendons, abnormality of the ulnar radial or median nerve and masses of the elbow joint. There are no significant findings to warrant (MRI) magnetic resonance imaging of left elbow. The request for (MRI) magnetic resonance imaging of left elbow is not medically necessary.

MRI bilateral hips: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline (ODG), Hip & Pelvis (Acute & Chronic), MRI (magnetic resonance imaging).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (MRI) magnetic resonance imaging, Hip & Pelvis.

Decision rationale: (MRI) magnetic resonance imaging of the hips is recommended by ODG only for osseous, articular or soft tissue abnormalities, osteonecrosis, occult acute and stress fracture, acute and chronic soft tissue injuries and tumors. (MRI) magnetic resonance imaging is the most accepted form of imaging for finding avascular necrosis of the hip and osteonecrosis. In this case the treating provider does not indicate any of these diagnoses in this injured worker. Records indicate injured worker had negative MRI of both hips performed on 2/17/2014. Based on medical records and guidelines cited, the request for MRI bilateral hips is not medically necessary and appropriate.

Terocin patches (unknown prescription): 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 analgesics Page(s): 111-113.

Decision rationale: There is no documentation provided necessitating the use of the requested topical medication, Terocin. 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. Methyl salicylate is recommended, topical lidocaine is not recommended if it is not Lidoderm and menthol is not discussed. There is no documentation of intolerance to other previous medications. Medical necessity for the requested topical medication has not been established. The requested treatment is not medically necessary.