

Case Number:	CM15-0185413		
Date Assigned:	10/05/2015	Date of Injury:	07/22/2014
Decision Date:	12/16/2015	UR Denial Date:	08/12/2015
Priority:	Standard	Application Received:	09/21/2015

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: California
 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 21 year old, who sustained an industrial injury on 07-22-2014. A review of the medical records indicates that the injured worker (IW) is undergoing treatment for bilateral wrist strain or sprains, carpal tunnel syndrome, lumbar spine strain or sprain, lumbar radiculopathy, and right knee strain or sprain. Medical records (03-12-2015 to 08-04-2015) indicate ongoing constant burning bilateral wrist pain rated 5 out of 10 in severity on a visual analog scale (VAS), constant, burning and radiating low back pain rated 5 out of 10 in severity on the VAS with associated numbness and tingling in both lower extremities, and constant, burning right knee pain rated 4-5 out of 10 in severity on the VAS. Records also indicate no changes in activity levels and level of functioning. Per the treating physician's progress report (PR), the IW has not returned to work. The physical exam, dated 08-04-2015, revealed tenderness at the carpal tunnel and the first dorsal extensor muscle compartment, restricted range of motion (ROM) with flexion and extension in the bilateral wrist, decreased sensation over the C5 through T1 dermatomes in the bilateral upper extremities, slightly decreased motor strength in all muscle groups of the bilateral upper extremities, tenderness to palpation over the lumbar paraspinal muscles and over the lumbosacral junction, trigger points noted in the PSIS (posterior superior iliac spine), sciatic notch tenderness, restricted ROM in all planes of the lumbar spine, tenderness to palpation over the medial and lateral joint lines and the patellofemoral joint of the right knee, mildly restricted flexion in the right knee, slightly decreased sensation in the right lower extremity, and slightly decreased motor strength in the bilateral lower extremities. Relevant treatments have included: physical therapy (PT) with temporary benefit, chiropractic

treatments with temporary benefit, acupuncture with temporary benefit, work restrictions, and medications. Current medications include topical ketoprofen and cyclobenzaprine, Synapryn oral suspension, tabradol oral suspension, Deprizine oral suspension, Dicopanol oral suspension and Fanatrex oral suspension which were reported to provide temporary relief of pain and improve his ability for restful sleep. The medical records included the following diagnostic test results: MIR of the left wrist (07-2015), MRI of the right knee (07-2015), and MRI of the lumbar spine (07-24-2015). The request for authorization (08-04-2015) shows that the following services and medications were requested: 18 sessions of acupuncture for the left wrist and right knee, MR arthrogram of the left wrist, MRI of the bilateral wrist, MRI of the right knee, EMG (electromyography) and NCV (nerve conduction velocity) studies of the bilateral upper extremities, EMG and NCV studies of the bilateral lower extremities, 3 sessions of shockwave therapy for the wrists and right knee, 6 sessions of shockwave therapy for the lumbar spine, referral to an orthopedic surgeon, ketoprofen 20% cream 167gm, cyclobenzaprine 5% cream 110gm, Synapryn 10mg per 1ml oral suspension 250ml, tabradol 1mg per 1ml oral suspension 250ml, Deprizine 15mg per 1ml oral suspension 250ml, Dicopanol 5mg per 1ml oral suspension 150ml, and Fanatrex (gabapentin) 25mg per 1ml oral suspension 420ml. The original utilization review (08-12-2015) non-certified the request for 18 sessions of acupuncture for the left wrist and right knee, MR arthrogram of the left wrist, MRI of the bilateral wrist, MRI of the right knee, EMG (electromyography) and NCV (nerve conduction velocity) studies of the bilateral upper extremities, EMG and NCV studies of the bilateral lower extremities, 3 sessions of shockwave therapy for the wrists and right knee, 6 sessions of shockwave therapy for the lumbar spine, referral to an orthopedic surgeon, ketoprofen 20% cream 167gm, cyclobenzaprine 5% cream 110gm, Synapryn 10mg per 1ml oral suspension 250ml, tabradol 1 mg per 1ml oral suspension 250ml, Deprizine 15mg per 1ml oral suspension 250ml, Dicopanol 5mg per 1ml oral suspension 150ml, and Fanatrex (gabapentin) 25mg per 1ml oral suspension 420ml.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture x18 visits for the left wrist and right knee: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: The Acupuncture Medical Treatment Guidelines state that the initial authorization for acupuncture is for 3-6 treatments. Authorization for more than 6 treatments would be predicated upon documentation of functional improvement. The request for 18 treatments is greater than the number recommended for a trial to determine efficacy. This patient has already been approved for 6 sessions of acupuncture. No documentation of functional improvement from those sessions was provided for review. Acupuncture x18 visits for the left wrist and right knee is not medically necessary.

MR arthrogram of the left wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004. Decision based on Non-MTUS Citation Expert Panel on Musculoskeletal Imaging. ACR Appropriateness Criteria chronic wrist pain. (online publication). Reston (VA): American College of Radiology (ACR): 2012. 13p.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic), Radiography.

Decision rationale: The Official Disability Guidelines state that when initial radiographs are equivocal, or in the presence of certain clinical or radiographic findings, further imaging is appropriate. This may be as simple as an expanded series of special views or fluoroscopic spot films; or may include tomography, arthrography, bone scintigraphy, computed tomography (CT), or magnetic resonance (MR) imaging. There was no documentation or objective findings provided which support this request. MR arthrogram of the left wrist is not medically necessary.

MRI of the bilateral wrists (single positional): Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist and Hand (Acute & Chronic): MRIs (magnetic resonance imaging), 2015.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic), MRIs (magnetic resonance imaging).

Decision rationale: The Official Disability Guidelines recommend an MRI of the wrist or indications following trauma, suspected fracture, tumor, and suspected Kienbck's disease. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Documentation in the medical record does not support an MRI of the wrist based on the above criteria. Detailed evidence of severe and/or progressive deficits has not been documented. MRI of the bilateral wrists (single positional) is not medically necessary.

MRI of the right knee (single positional): Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic), MRIs (magnetic resonance imaging).

Decision rationale: The Official Disability Guidelines state that an MRI of the knee is indicated if internal derangement is suspected. No red-flag indications are present in the medical record. Detailed evidence of severe and/or progressive deficits has not been documented. Evidence of a

recent comprehensive conservative treatment protocol trial and failure has not been submitted. MRI of the right knee (single positional) is not medically necessary.

EMG/NCV of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, and Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back-Lumbar & Thoracic (Acute & Chronic): Nerve conduction studies (NCS), 2015.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The MTUS states that electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. This patient was approved for an EMG of the bilateral upper extremities on 11/21/2014. Detailed evidence of new severe and/or progressive neurological abnormalities has not been documented. EMG/NCV of the bilateral upper extremities is not medically necessary.

EMG/NCV of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, and Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back-Lumbar & Thoracic (Acute & Chronic): Nerve conduction studies (NCS), 2015.

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 (Acute & Chronic), Nerve conduction studies (NCS).

Decision rationale: According to the Official Disability Guidelines, nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. This patient was approved for an EMG of the bilateral lower extremities on 11/21/2014. Detailed evidence of new severe and/or progressive neurological abnormalities has not been documented. EMG/NCV of the bilateral lower extremities is not medically necessary.

Shockwave therapy treatments x3 for the wrists and right knee: 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), Knee & Leg (Acute & Chronic): Extracorporeal shock wave therapy (ESWT), 2015.

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

Decision rationale: According to the Official Disability Guidelines, limited evidence exists regarding extracorporeal shock wave therapy (ESWT) in reducing pain and improving function. While it appears to be safe, there is disagreement as to its efficacy. Insufficient high quality scientific evidence exists to determine clearly the effectiveness of this therapy and it is not recommended. Shockwave therapy treatments x3 for the wrists and right knee is not medically necessary.

Shockwave therapy treatments x6 for the 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), Low Back-Lumbar & Thoracic (Acute & Chronic): Shock wave therapy (2015).

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

Decision rationale: According to the Official Disability Guidelines, limited evidence exists regarding extracorporeal shock wave therapy (ESWT) in reducing pain and improving function. While it appears to be safe, there is disagreement as to its efficacy. Insufficient high quality scientific evidence exists to determine clearly the effectiveness of this therapy and it is not recommended. Shockwave therapy treatments x6 for the lumbar spine is not medically necessary.

Referral to an orthopedic surgeon: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Cornerstones of Disability Prevention and Management.

Decision rationale: According to the American College of Occupational and Environmental Medicine Occupational Medicine Practice Guidelines, 2nd Edition, a referral request should specify the concerns to be addressed in the independent or expert assessment, including the relevant medical and non-medical issues, diagnosis, causal relationship, prognosis, temporary or permanent impairment, workability, clinical management, and treatment options. The medical record lacks sufficient documentation regarding which body parts are to be addressed and does not support a referral request. Referral to an orthopedic surgeon is not medically necessary.

Ketoprofen 20% cream, 167gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Ketoprofen agent is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. Ketoprofen 20% cream, 167gm is not medically necessary.

Cyclobenzaprine 5% cream, 110gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is no evidence for use of any muscle relaxant as a topical product. Cyclobenzaprine 5% cream, 110gm is not medically necessary.

Synapryn 10mg/1ml oral suspension, 250ml: 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 (Chronic), Compound drugs.

Decision rationale: The requested compound medication contains unnamed and then defined "other proprietary ingredients". In addition, there is no documentation that the patient has a contraindication to medication prescribed in tablet form. According to the Official Disability Guidelines, compounded drugs are not recommended as a first-line therapy. In general, commercially available, FDA-approved drugs should be given an adequate trial. If these are found to be ineffective or are contraindicated in individual patients, compound drugs that use FDA-approved ingredients may be considered. There is no documentation that the FDA

approved medication was given an adequate trial. Synapryn 10mg/1ml oral suspension, 250ml is not medically necessary.

Tabradol 1mg/ml, 250ml: 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 (Chronic), Compound drugs.

Decision rationale: The requested compound medication contains unnamed and then defined "other proprietary ingredients". In addition, there is no documentation that the patient has a contraindication to medication prescribed in tablet form. According to the Official Disability Guidelines, compounded drugs are not recommended as a first-line therapy. In general, commercially available, FDA-approved drugs should be given an adequate trial. If these are found to be ineffective or are contraindicated in individual patients, compound drugs that use FDA-approved ingredients may be considered. There is no documentation that the FDA approved medication was given an adequate trial. Tabradol 1mg/ml, 250ml is not medically necessary.

Deprizine 15mg/ml oral suspension, 250ml: 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 (Chronic), Compound drugs.

Decision rationale: The requested compound medication contains unnamed and then defined "other proprietary ingredients". In addition, there is no documentation that the patient has a contraindication to medication prescribed in tablet form. According to the Official Disability Guidelines, compounded drugs are not recommended as a first-line therapy. In general, commercially available, FDA-approved drugs should be given an adequate trial. If these are found to be ineffective or are contraindicated in individual patients, compound drugs that use FDA-approved ingredients may be considered. There is no documentation that the FDA approved medication was given an adequate trial. Deprizine 15mg/ml oral suspension, 250ml is not medically necessary.

Dicopanol 5mg/ml oral suspension, 150ml: 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 (Chronic), Compound drugs.

Decision rationale: The requested compound medication contains unnamed and then defined "other proprietary ingredients". In addition, there is no documentation that the patient has a contraindication to medication prescribed in tablet form. According to the Official Disability Guidelines, compounded drugs are not recommended as a first-line therapy. In general, commercially available, FDA-approved drugs should be given an adequate trial. If these are found to be ineffective or are contraindicated in individual patients, compound drugs that use FDA-approved ingredients may be considered. There is no documentation that the FDA approved medication was given an adequate trial. Dicopanol 5mg/ml oral suspension, 150ml is not medically necessary.

Fanatrex (Gabapentin) 25mg/ml oral suspension, 420ml: 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 (Chronic), Compound drugs.

Decision rationale: The requested compound medication contains unnamed and then defined "other proprietary ingredients". In addition, there is no documentation that the patient has a contraindication to medication prescribed in tablet form. According to the Official Disability Guidelines, compounded drugs are not recommended as a first-line therapy. In general, commercially available, FDA-approved drugs should be given an adequate trial. If these are found to be ineffective or are contraindicated in individual patients, compound drugs that use FDA-approved ingredients may be considered. There is no documentation that the FDA approved medication was given an adequate trial. Fanatrex (Gabapentin) 25mg/ml oral suspension, 420ml is not medically necessary.