

Case Number:	CM15-0188434		
Date Assigned:	10/02/2015	Date of Injury:	07/10/2014
Decision Date:	12/08/2015	UR Denial Date:	08/28/2015
Priority:	Standard	Application Received:	09/24/2015

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 56 year old male, who sustained an industrial injury on 7-10-2014. Medical records indicate the worker is undergoing treatment for cervical spine pain with radiculopathy and herniated nucleus pulposus, bilateral shoulder pain, bilateral elbow internal derangement, bilateral wrist pain, thoracic spine pain, low back pain, lumbar herniated nucleus pulposus, bilateral knee pain, right ankle pain, anxiety, stress and mood and sleep disorder. A recent progress report dated 7-28-2015, reported the injured worker complained of neck pain with muscle spasm rated 5-6 out of 10, bilateral shoulder pain radiating down the arms with muscle spasm rated 6 out of 10, bilateral elbow pain and muscle spasm rated 6 out of 10, bilateral wrist pain and muscle spasm rated 4-5 out of 10, mid back pain with muscle spasm rated 4-5 out of 10, low back pain with muscle spasm rated 6 out of 10, bilateral knee pain rated 5 out of 10, right ankle pain rated 5-6 out of 10, frustration, stress, anxiety, insomnia and depression. Physical examination revealed sub occipital tenderness to palpation, bilateral shoulder tenderness, bilateral elbow tenderness, bilateral wrist tenderness, bilateral knee tenderness, right ankle tenderness, tenderness over the thoracic spine and lumbar paraspinal tenderness with trigger points and muscle spasm. Lumbar range of motion was flexion of 40 degrees, extension of 15 degrees, right and left lateral flexion of 20 degrees, left rotation of 20 degrees and right rotation of 15 degrees. Treatment to date has included acupuncture, chiropractic care, physical therapy and medication management. On 7-28-2015, the Request for Authorization requested lumbar magnetic resonance imaging, 18 sessions of lumbar acupuncture, 18 sessions of lumbar physical therapy, cane, consultation with pain management specialist regarding epidural steroid injection of the lumbar spine, 6 sessions of shockwave

therapy to the lumbar spine, Ketoprofen 20% cream 167 grams, Cyclobenzaprine 5% cream 110 grams, Synapryn oral suspension 10mg per 1ml-500ml, Tabradol oral suspension 1mg per ml-250ml, Deprizine oral suspension 15 mg per ml-250 ml, Dicopanol oral suspension 5mg per ml-150 ml, Fanatrex oral suspension 25mg per ml-420 ml and a urine drug screen. On 8-27-2015, the Utilization Review noncertified the request for lumbar magnetic resonance imaging, 18 sessions of lumbar acupuncture, 18 sessions of lumbar physical therapy, cane, Consultation with pain management specialist regarding epidural steroid injection of the lumbar spine, 6 sessions of shockwave therapy to the lumbar spine, Ketoprofen 20% cream 167 grams, Cyclobenzaprine 5% cream 110 grams, Synapryn oral suspension 10mg per 1ml-500ml, Tabradol oral suspension 1mg per ml-250ml, Deprizine oral suspension 15 mg per ml-250 ml, Dicopanol oral suspension 5mg per ml-150 ml, Fanatrex oral suspension 25mg per ml-420 ml and a urine drug screen.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Magnetic resonance imaging (MRI).

Decision rationale: As per Official Disability Guidelines (ODG) MRI (magnetic resonance imaging) is indicated for Lumbar spine trauma: 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 (eg, tumor, infection, fracture, neurocompression, and 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, and the treating provider notes no concerning changes in neurological exam, and there are no red flags. Therefore, the request for MRI Lumbar spine is not medically necessary and appropriate.

Acupuncture lumbar spine, 18 sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: This prescription for acupuncture is evaluated in light of the MTUS recommendations for acupuncture. The MTUS recommends an initial trial of 3-6 visits of 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. Medical necessity for any further acupuncture is considered in light of functional improvement. This injured worker has received treatment with acupuncture before, however the records are not clear about its functional benefits. There was no discussion by the treating physician regarding a decrease or intolerance to pain medications. Also 18 sessions of acupuncture exceed the MTUS recommendation. Given the MTUS recommendations for use of acupuncture, the requested treatment Acupuncture lumbar spine, 18 sessions is not medically necessary.

Physical therapy lumbar spine, 18 sessions: 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): Physical Medicine.

Decision rationale: The prescription for Physical Therapy is evaluated in light of the MTUS recommendations for Physical Therapy. MTUS recommends: 1) Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. 2) Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The records do not indicate functional benefit from prior physical therapy visits. Also there is no mention of any significant change of symptoms or clinical findings, or acute flare up to support PT. The request for 18 sessions of physical therapy is not medically necessary and appropriate.

Cane: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Walking aids (canes, crutches, braces, orthoses, & walkers).

Decision rationale: The California MTUS Guidelines are silent regarding the use of canes. According to the Official Disability Guidelines (ODG), state that "disability, pain, and age-related impairments seem to determine the need for a walking aid." Nonuse is associated with less need, negative outcome, and negative evaluation of the walking aid. Contralateral cane placement is the most efficacious for persons with knee osteoarthritis. After review of the received medical records, there are no documented subjective or objective findings that would support the need for a cane. Therefore, based on the Guidelines and the submitted records, the request for a cane is not medically necessary.

Consultation with pain management specialist regarding epidural steroid injection of the lumbar spine: Overturned

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

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, Epidural steroid injections (ESIs).

Decision rationale: This requested treatment for Epidural steroid injections (ESIs) is evaluated in light of the CA MTUS and the Official Disability Guidelines (ODG) recommendations. The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. ODG criteria do not recommend additional epidural steroid injections, if significant improvement is not achieved with an initial treatment. Review of medical documentation does specify radiculopathy, corroborated by imaging studies and electrodiagnostic testing. Medical Records of the injured worker do indicate failure of conservative treatment in the past, and no evidence of such procedure in the past. The requested treatment: Consultation with pain management specialist regarding epidural steroid injection of the lumbar spine is medically necessary.

Shockwave therapy lumbar spine, 6 sessions: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: CA MTUS does not address this, therefore, the requested treatment is evaluated in light of Official Disability Guidelines (ODG). Extracorporeal shock wave therapy (ESWT) 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. Two small studies

have been published for upper back or neck pain. In this study trigger point treatment with radial shock wave used in combination with physical therapy provided temporary relief of neck and shoulder pains, but the effects of radial shock wave without physical therapy need to be examined in further studies. The medical records do not include any clear rationale for such treatment. The requested treatment: Shockwave therapy lumbar spine, 6 sessions is not medically necessary.

Ketoprofen 20% cream 167 gm: 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: 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. Note that topical 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 requested treatment: Ketoprofen 20% cream 167 gm for is not medically necessary.

Cyclobenzaprine 5% cream 110 gm: 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: Per the CA MTUS guidelines, although recommended as an option, topical analgesics are used primarily for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Furthermore, they are largely experimental. "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 that this patient has tried taking antidepressants and/or anticonvulsants for neuropathic pain. "There is no evidence for use of any other muscle relaxant (Cyclobenzaprine) as a topical product." The requested treatment: Cyclobenzaprine 5% cream 110 gm is not medically necessary.

Synapryn oral suspension 10mg/1ml 500 ml: 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): Glucosamine (and Chondroitin Sulfate), Opioids for chronic pain.

Decision rationale: 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 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 oral suspension 1mg/ml 250 ml: 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): Muscle relaxants (for pain).

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 in the extremity, not the low back. 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. Prescribing was not for a short term exacerbation. Multiple medications, including a topical muscle relaxant, were prescribed together without adequate trials of each. Per the MTUS, Cyclobenzaprine is not indicated. The Requested Treatment: Tabradol oral suspension 1mg/ml 250 ml is not medically necessary.

Deprizine oral suspension 15 mg/ml 250 ml: 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): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: The prescription for Deprizine is evaluated in light of the MTUS recommendations. Deprizine is ranitidine in an oral suspension. There is no documentation indicating the patient has any GI symptoms or GI risk factors. Risk factors include, age 65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. If ranitidine is prescribed as co-therapy with an NSAID, ranitidine is not the best drug. 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. Medical necessity of the requested item has not been established.

Dicopanol oral suspension 5mg/ml 150 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).

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: Official Disability Guidelines (ODG) state Over-the-counter medications: Sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine). Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. Side effects include urinary retention, blurred vision, orthostatic hypotension, dizziness, palpitations, increased liver enzymes, drowsiness, dizziness, grogginess and tiredness. The treating physician has stated that Dicopanol is diphenhydramine and other proprietary 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. 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. Official Disability Guidelines state that antihistamines are not indicated for long term use as tolerance develops quickly, and that there are many, significant side effects. MTUS states 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. Dicopanol is not medically necessary based on lack of a sufficient analysis of the patient's condition, and lack of information provided about the ingredients.

Fanatrex oral suspension 25mg/ml 420 ml: 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): Antiepilepsy drugs (AEDs).

Decision rationale: Per the MTUS, Fanatrex (Gabapentin) is a compounded form of an anti-epilepsy drug (AEDs), also referred to as anti-convulsants. These drugs have been shown to be effective for treatment of diabetic painful neuropathy/polyneuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. FDA-approved drugs should be given adequate trial, if these are inadequate, ineffective or contraindicated in the individual patient, then compounded drugs with FDA approved ingredients can be considered. The clinical documentation submitted for review does not indicate diagnoses of diabetic neuropathy or postherpetic neuralgia. Painful neuropathic symptoms were noted; however, there is no indication for the compounded oral suspension form of this drug in such a low dose (non-therapeutic dose) in comparison to the recommended dose of oral gabapentin in tablet form. In addition, there is no documented failed trial of the FDA approved form of this drug, and no indication as to the reason that the FDA-approved form is contraindicated in the injured worker. As such, the request for Fanatrex (Gabapentin) 25mg/ml 420ml is not medically necessary

Urine drug screen: 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): Drug testing. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Urine Drug Testing (UDT).

Decision rationale: This request for urine drug test is evaluated in light of the Official Disability Guidelines (ODG) for Urine Drug Testing (UDT). ODG state (1) UDT is recommended at the onset of treatment of a new patient who is already receiving a controlled substance or when chronic opioid management is considered. Urine drug testing is not generally recommended in acute treatment settings (i.e. when opioids are required for nociceptive pain). (2) In cases in which the patient asks for a specific drug. This is particularly the case if this drug has high abuse potential, the patient refuses other drug treatment and/or changes in scheduled drugs, or refuses generic drug substitution. (3) If the patient has a positive or at risk addiction screen on evaluation. This may also include evidence of a history of comorbid psychiatric disorder such as depression, anxiety, bipolar disorder, and/or personality disorder. See Opioids, screening tests for risk of addiction & misuse. (4) If aberrant behavior or misuse is suspected and/or detected. Review of Medical Records do not indicate substance abuse, noncompliance, or aberrant behavior. Also Synapryn is determined to be not medically necessary. The treating provider does not provide any documentation about the need for Urine Toxicology. Guidelines are not met, therefore, the request for Urine Toxicology Screen is not medically necessary