

Case Number:	CM15-0021320		
Date Assigned:	02/10/2015	Date of Injury:	10/25/2013
Decision Date:	04/08/2015	UR Denial Date:	01/08/2015
Priority:	Standard	Application Received:	02/03/2015

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: Anesthesiology

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 27 year old male, who sustained an industrial injury on 10/25/2013. He has reported a shelf fell suddenly landing on his head and neck. Diagnoses include headaches, cervical spine herniated nucleus pulposus, cervical radiculopathy, low back pain, lumbar spine herniated nucleus pulposus, and lumbar radiculopathy. Treatment to date has included physiotherapy to the lumbar and cervical spine, chiropractic therapy to the cervical and lumbar spine, shockwave therapy to the lumbar and cervical spine, neurostimulation therapy to the lumbar spine, magnetic resonance imaging of the cervical spine, magnetic resonance imaging of the lumbar spine, and medication regimen. In a progress note dated 12/26/2014 the treating provider reports of headaches; burning, constant, moderate to severe radicular neck pain; and burning, constant, moderate to severe radicular low back pain. The neck pain is rated a six out of ten and the back pain is rated a six to seven out of ten. The injured worker also had complaints of numbness and tingling to the bilateral lower extremities. On 01/08/2015 Utilization Review non-certified the requested treatment Ketoprofen 20% Cream 165grams, Cyclobenzaprine 5% Cream 100grams, Synapryn 10mg/1 ml oral suspension 500ml, Tabradol 1mg/ml oral suspension 250ml, Deprizine 15mg/ml oral suspension 250ml, Dicopanol 5mg/ml oral suspension 150ml, Fanatrex 25mg/ml oral suspension 420ml, physiotherapy 3 times a week for 6 weeks for the cervical and lumbar spine, chiropractic treatments 3 times a week for 6 weeks for the cervical and lumbar spine, shockwave therapy times 6 treatments for the cervical and lumbar spine, localized intense neurostimulation therapy 1 time a week for 6 weeks for the lumbar spine, Terocin Patches, pain management consult for cervical epidural steroid injection and lumbar

epidural steroid injection, and follow-up evaluation, noting the California Medical Treatment Utilization Schedule, 2009, Chronic Pain Medical Treatment Guidelines: pages 111 to 113, pages 93 to 94, pages 78 to 80, page 91, page 124, page 50, pages 63 to 64, pages 68 to 69, pages 16 to 17, pages 18 to 19, page 99, pages 114 to 116; American College of Occupational and Environmental Medicine Guidelines: Neck and Upper Back Complaints; Low Back Complaints; American College of Occupational and Environmental Medicine Occupation Medicine Practice Guidelines, 2nd Edition, 2004, page 127; and Official Disability Guidelines: Pain (updated 12/31/2014); Neck & Upper Back (updated 11/18/2014); Low Back (Updated 11/21/2014); and Low Back-Lumbar & Thoracic (updated 11/21/2014).

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 20% Cream 165grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111,113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Compound Drugs.

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

Decision rationale: According to the California MTUS Guidelines (2009), 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, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the topical analgesic is Ketoprofen 20% cream. Ketoprofen is not currently FDA approved for a topical application, and has an extremely high incidence of photocontact dermatitis. Medical necessity for the requested topical medications have not been established. The requested topical creams are not medically necessary.

Cyclobenzaprine 5% Cream 100grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111, 113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Compound Drugs.

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

Decision rationale: According to the California MTUS Guidelines (2009), 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, muscle relaxants, local anesthetics or antidepressants. In this case, the requested topical agent is a muscle relaxant, Cyclobenzaprine 5% Cream. Cyclobenzaprine is not recommended as a topical agent, per CA MTUS guidelines. Medical necessity for the requested topical medications is not established. The requested topical cream is not medically necessary.

Synapryn 10mg/1 ml Oral Suspension 500ml: 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 for the treatment of chronic pain Page(s): 93-96.

Decision rationale: According to the California MTUS, Synapryn oral suspension (Tramadol hydrochloride) is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. According to the medical records, there has been no documentation of the medication's analgesic effectiveness or functional improvement, and no clear documentation that the patient has responded to ongoing opioid therapy. An oral suspension is a suspension consisting of undissolved particles of one or more medicinal agents mixed with a liquid vehicle for oral administration. Evidence-based guidelines and peer-reviewed medical literature do not address the use of medications in oral suspension form. Oral suspensions of medications are generally for use in patients for whom taking the pill/tablet form of the medication is either impractical or unsafe. In this case, there is no documentation in the medical records of any conditions that would preclude the use of medications in their pill/tablet form. Medical necessity for the requested Synapryn 10mg/1 ml Oral Suspension is not established. Of note, discontinuation of an opioid analgesic requires a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

Tabradol 1mg/ml Oral Suspension 250ml: 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): 41.

Decision rationale: According to the reviewed literature, Tabradol (Cyclobenzaprine) oral suspension is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. According to CA MTUS Guidelines, muscle

relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. In this case, there are no muscle spasms documented on physical exam. There is no documentation of functional improvement from any previous use of this medication. Tabradol oral suspension is a suspension consisting of undissolved particles of one or more medicinal agents mixed with a liquid vehicle for oral administration. Evidence-based guidelines and peer-reviewed medical literature do not address the use of medications in oral suspension form. Oral suspensions of medications are generally for use in patients for whom taking the pill/tablet form of the medication is either impractical or unsafe. In this case, there is no documentation in the medical records of any conditions that would preclude the use of medications in their pill/tablet form. Based on the currently available information, the medical necessity for Tabradol 1mg/ml Oral Suspension has not been established. The requested medication 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 UpToDate.

Decision rationale: Deprizine 15mg/ml Oral Suspension (Ranitidine) is a histamine blocker and antacid used to treat peptic ulcers, gastritis and gastroesophageal reflux (GERD). Ranitidine works by blocking the effects of histamine on the receptor site known as H2. Proton Pump Inhibitors (PPI's) are prescribed to both prevent and treat ulcers in the duodenum (where most ulcers develop) and the stomach. They also counter the various problems that occur when stomach acid escapes into the esophagus, which if it happens on a regular basis, is GERD. In most trials, the PPIs have proved to be superior to the H2 blockers. Deprizine oral suspension is a suspension consisting of undissolved particles of one or more medicinal agents mixed with a liquid vehicle for oral administration. Evidence-based guidelines and peer-reviewed medical literature do not address the use of medications in oral suspension form. Oral suspensions of medications are generally for use in patients for whom taking the pill/tablet form of the medication is either impractical or unsafe. In this case, there is no documentation in the medical records of any conditions that would preclude the use of medications in their pill/tablet form. Medical necessity of the Deprizine (Ranitidine) oral suspension has not been established. The requested medication is not medically necessary.

Dicopanol 5mg/ml Oral Suspension 150ml: 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) updated 12/31/14, Insomnia Treatment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation UpToDate.

Decision rationale: Diphenhydramine is an antihistamine that is used for the temporary relief of seasonal and perennial allergy symptoms. The medication is sedating and has been used for short-term treatment of insomnia. There is no documentation indicating the patient has any history of insomnia. Dicopanorol 5mg/ml, the oral suspension form of Diphenhydramine, is generally for use in patients for whom taking the pill/tablet form of the medication is either impractical or unsafe. In this case, there is no documentation in the medical records of any conditions that would preclude the use of medications in their pill/tablet form. Medical necessity for the requested oral suspension medication is not established. The requested medication is not medically necessary.

Fanatrex 25mg/ml Oral Suspension 420ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy Drug (AEDs) Page(s): 16-17, 18-19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDs) Page(s): 17-19. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fanatrex Oral Suspension (Gabapentin).

Decision rationale: According to the CA MTUS (2009) and ODG, Fanatrex Oral Suspension (Gabapentin) is an anti-epilepsy drug, which has been considered a first-line treatment for neuropathic pain. Oral suspensions of medications are generally for use in patients for whom taking the pill/tablet form of the medication is either impractical or unsafe. In this case, there is no documentation in the medical records of any conditions that would preclude the use of medications in their pill/tablet form. Medical necessity for the requested medication, Fanatrex 25mg/ml Oral Suspension, is not established. The requested medication is not medically necessary.

Physiotherapy 3 Times a Week for 6 Weeks for the Cervical and Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical Therapy (PT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Recommendations state that for most patients with more severe and sub-acute low back pain conditions, 8 to 12 visits over a period of 6 to 8 weeks is indicated and ODG recommends that for most patients with more severe and sub-acute neck pain conditions up to 10 visits are indicated. Treatment is continued as long as functional improvement and program progression are documented. 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. 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 assisting devices. In this case, the patient has completed prior physical therapy sessions but there is no documentation indicating that he had a defined functional improvement in his condition. There is no specific indication for the requested additional PT sessions. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

Chiropractic Treatments 3 Times a Week for 6 Weeks for the Cervical and Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Manipulation, and Chiropractic Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58-60.

Decision rationale: Per the MTUS Guidelines, chiropractic manipulation is a treatment option during the acute phase of injury, and manipulation should not be continued for more than a month, particularly when there is not a good response to treatment. The intended goal or effect is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. For the treatment of low back pain, a trial of 6 visits is recommended over 2 weeks, with evidence of objective improvement, with a total of up to 18 visits over 6-8 weeks. The ODG states that cervical manipulation may be an option for patients with occupationally related neck pain or cervicogenic headache. ODG recommends up to 18 total chiropractic and massage visits over 6-8 weeks for cervical and thoracic injuries with evidence of functional improvement after a 6 visit initial trial. In this case, there is no documentation of number of previous chiropractic visits and no documentation of functional improvement from the completed sessions. Medical necessity for the requested service is not established. The requested service is not medically necessary.

Shockwave Therapy Times 6 Treatments for the Cervical and Lumbar Spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar & Thoracic (updated 11/21/14), Shockwave Therapy (PT).

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.

Decision rationale: Extracorporeal shock wave therapy (ESWT) is a noninvasive treatment proposed to treat refractory tendonopathies such as, plantar fasciitis. It has also been introduced

as an alternative to surgery for patients that have not responded to other conservative therapies. ESWT is a noninvasive treatment that involves delivery of low or high energy shock waves via a device to a specific site within the body. These pressure waves travel through fluid and soft tissue; their effects occur at sites where there is a change in impedance, such as the bone/soft tissue interface. In this case, there is documentation that this patient has had previous ESWT. There is no documentation indicating functional improvement. However, guidelines do not support ESWT for the cervical or lumbar spine. Medical necessity for the requested procedures has not been established. The requested ESWTs (x6 treatments) for the cervical and lumbar spine are not medically necessary.

Localized Intense Neurostimulation Therapy 1 Time a week for 6 weeks for the Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, and TENS Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-116. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) .

Decision rationale: According to the MTUS, electrotherapy represents the therapeutic use of electricity and is another modality that can be used in the treatment of pain. Transcutaneous electrotherapy is the most common form of electrotherapy where electrical stimulation is applied to the surface of the skin. The earliest devices were referred to as TENS (transcutaneous electrical nerve stimulation) and are the most commonly used. It should be noted that there is not one fixed electrical specification that is standard for TENS; rather there are several electrical specifications. Other devices (e.g., H wave stimulation, Interferential Current Stimulation, and Microcurrent electrical stimulation (MENS)) have been designed and are distinguished from TENS based on their electrical specifications. In this case, the patient had a previous trial of intense neuro-stimulation and there is no documentation of any improvement in his pain or functional status. Medical necessity for the requested localized Intense Neuro-stimulation Therapy (1 Time a week for 6 weeks) for the lumbar spine has not been established. The requested therapy is not medically necessary.

Terocin Patches: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

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. There is no documentation of intolerance to other previous medications. Medical necessity for the requested topical medication has not been established. The requested Terocin patches are not medically necessary.

Pain Management Consult for Cervical Epidural Steroid Injection and Lumbar Epidural Steroid Injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7, Independent Medical Examinations and Consultations, page 127.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 127, Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Epidural Steroid Injections.

Decision rationale: A referral to a specialist for consultation can aid in a diagnosis, prognosis, therapeutic management, determination of medical stability, and determination of the examinee's fitness for return to work. This case involves a request for a Pain Management consult for cervical and lumbar epidural steroid injections (ESIs). They are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Most current guidelines recommend no more than 2 ESI injections. Research has shown that, on average, less than two injections are required for a successful ESI outcome. ESIs can offer short-term pain relief and use should be in conjunction with other rehab efforts. The purpose of ESIs 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. The patient must be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). In this case, there are no objective findings on physical exam or corroborating diagnostic findings of radiculopathy. MTUS and ODG guidelines do not support treatment with lumbar ESIs in the absence of radiculopathy. Medical necessity for the requested ESIs has not been established. The requested Pain Management consult for CESI and LESI is not medically necessary.

Follow-Up Evaluation: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints.

Decision rationale: Although there have been no new recommendations for any of the requested medications or treatments, this patient has chronic pain conditions which continue to require regular follow-up visits. Patients whose neck or upper back complaints, or low back complaints that are work related, should receive follow-up care every 3 to 5 days by a mid-level practitioner, who can counsel them about avoiding static positions, medication use, activity modification, and other concerns. Physician follow-up generally occurs when a release to modified, increased, or full duty is needed, or after appreciable healing or recovery can be expected, on average. Physician follow-up might occur every 4 to 7 days if the patient is off work, and 7 to 14 days if the patient is working. Medical necessity for the follow-up evaluation has been established. The requested follow-up evaluation is medically necessary.