

Case Number:	CM15-0030343		
Date Assigned:	03/26/2015	Date of Injury:	08/01/2014
Decision Date:	05/12/2015	UR Denial Date:	02/02/2015
Priority:	Standard	Application Received:	02/18/2015

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: Physical Medicine & Rehabilitation

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 49-year-old male who reported injury on 08/01/2014. The mechanism of injury was not provided. There was a Request for Authorization submitted for review dated 12/22/2014. The documentation of 12/21/2014 revealed the injured worker had complaints of neck pain rated a 7/10. The injured worker had bilateral shoulder pain and low back pain. The injured worker indicated pain was alleviated with medications, rest, and activity restriction. The physical examination revealed tenderness to palpation in the paraspinal muscles of the cervical spine. The injured worker had decreased range of motion. The injured worker had tenderness at the deltopectoral group and at the insertion of the supraspinatus muscle on the bilateral shoulders. The injured worker had decreased range of motion of the bilateral shoulders. Sensation to pinprick and light touch was slightly diminished over C4-T1 dermatomes in the bilateral upper extremities. Motor strength was 4/5 in all muscle groups in the bilateral upper extremities. Reflexes were 2+ and symmetrical. The examination of the lumbar spine revealed palpable tenderness with spasm in the lumbar paraspinal muscles. Range of motion of the lumbar spine was decreased. Sensation was decreased at L4-S1 dermatomes bilaterally. Motor strength was 4/5 in all muscle groups in the bilateral lower extremities. The diagnoses include cervical spine pain, cervical spine radiculopathy, bilateral shoulder sprain and strain, low back pain, and radiculitis, lower extremity. The treatment plan included Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, physical therapy, chiropractic care and acupuncture, shockwave therapy, a psychologist referral, MRI of the cervical and lumbar spine and bilateral shoulders, EMG/NCV of the bilateral upper and lower extremities, a pain management specialist for epidural steroid

injections for the cervical and lumbar spine, PRP injections for the cervical and lumbar spine and bilateral shoulders, and Terocin patches.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription of Synapryn 10mg: 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 Glucosamine Sulfate, Ongoing Management, Tramadol Page(s): 50,78,82, 93, & 94. Decision based on Non-MTUS Citation Synapryn online drug insert.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend tramadol for pain; however, do not recommend it as a first line oral analgesic and they recommend glucosamine sulfate for patients with moderate arthritis pain, especially knee osteoarthritis, and that only 1 medication should be given at a time. Synapryn, per the online package insert, includes tramadol and glucosamine sulfate. The use of an oral suspension medication is only supported in the instances when the drug is unavailable in tablet or capsule form or when the patient's condition substantiates their inability to swallow or tolerate a pill. As tramadol is a form of an opiate, the California Medical Treatment Utilization Schedule Chronic Pain Guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the patient is being monitored for aberrant drug behavior and side effects. There was documentation the injured worker underwent urine drug screens. The clinical documentation submitted for review failed to provide documentation of objective pain relief and an objective improvement in function. There was a lack of documentation indicating the injured worker was being monitored for side effects. The request as submitted failed to indicate the frequency and specific quantity of medication being requested. Additionally, there was a lack of documentation indicating the injured worker had moderate arthritis. The duration of opiate use was not provided. Given the above, the request for 1 Prescription of Synapryn 10mg is not medically necessary.

1 Prescription of Tabradol 1mg: 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 Cyclobenzaprine Page(s): 41.

Decision rationale: Tabradol is a compounding kit for oral suspension of cyclobenzaprine and methylsulfonylmethane. A search of ACOEM, California Medical Treatment Utilization Schedule Guidelines, and Official Disability Guidelines, along with the National Guideline Clearinghouse (NCG) and the PubMed database returned no discussion on Tabradol. The use of

an oral suspension medication is only supported in the instances when the drug is unavailable in tablet or capsule form or when the patient's condition substantiates their inability to swallow or tolerate a pill. There was a lack of evidence based literature for the oral compounding of cyclobenzaprine and methylsulfonylmethane over the commercially available oral forms and the lack of medical necessity requiring an oral suspension of these medications. The clinical documentation submitted for review failed to provide documentation of exceptional factors. The request as submitted failed to indicate the frequency and specific quantity of the medication being requested. Given the above, the request for 1 Prescription of Tabradol 1mg is not medically necessary.

1 Prescription of Dicopanol 5mg: 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 www.drugs.com/search.php?searchterm=Dicopanol.

Decision rationale: The Official Disability Guidelines indicate that sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine) and that tolerance seems to develop within a few days. Per Drugs.com, Dicopanol is diphenhydramine hydrochloride and it was noted this drug has not been found by the FDA to be safe and effective and the labeling was not approved by the FDA. The use of an oral suspension medication is only supported in the instances when the drug is unavailable in tablet or capsule form or when the patient's condition substantiates their inability to swallow or tolerate a pill. The clinical documentation submitted for review failed to provide documentation the injured worker could not swallow a tablet or capsule. There was a lack of documentation indicating the injured worker had difficulty sleeping. The request as submitted failed to indicate the frequency and quantity of medication being requested. Given the above, the request for 1 Prescription of Dicopanol 5mg is not medically necessary.

18 Physical Therapy sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend physical medicine for up to 10 visits for myalgia and myositis and radiculitis. The clinical documentation submitted for review failed to provide documentation of the injured worker's prior treatments and the injured worker's objective functional response. There was a lack of documentation of objective functional deficits to support the necessity for physical therapy. Additionally, the request as submitted failed to indicate the body part to be treated with

physical therapy. Given the above, the request for 18 Physical Therapy sessions is not medically necessary.

18 Shockwave Therapy Treatments for the Cervical Spine only: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Wang, Ching-Jen. "Extracorporeal shockwave therapy in musculoskeletal disorders." Journal of orthopaedic surgery and research 7.1 (2012): 1-8.

Decision rationale: Per Wang, Ching-Jen (2012), "The application of extracorporeal shockwave therapy (ESWT) in musculoskeletal disorders has been around for more than a decade and is primarily used in the treatment of sports related over use tendinopathies such as proximal plantar fasciitis of the heel, lateral epicondylitis of the elbow, calcific or noncalcific tendonitis of the shoulder and patellar tendinopathy etc." The clinical documentation submitted for review failed to provide documentation of exceptional factors. There was a lack of documentation indicating the injured worker had a sports related overuse tendinopathy. Given the above, the request for 18 Shockwave Therapy Treatments for the Cervical Spine only is not medically necessary.

1 Single Positional MRI of the Cervical Spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The American College of Occupational and Environmental Medicine indicates the criteria for ordering imaging studies include the 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. Physiologic evidence may be in the form of definitive neurologic findings on examination, electrodiagnostic studies, laboratory tests, or bone scan. Additionally, they indicate, for most injured workers presenting with true neck or upper back problems, special studies are not needed unless a 3 or 4 week period of conservative care and observation fails to improve symptoms. While there were objective findings upon physical examination, there was a lack of documentation of conservative care specifically directed at the cervical spine. There was a lack of documentation of exceptional factors. Given the above, the request for 1 Single Positional MRI of the Cervical Spine is not medically necessary.

1 Referral to a Pain Management Specialist for a Consultation regarding Epidural Steroid Injections for the Cervical Spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic Pain Disorder Medical Treatment Guidelines, State of Colorado Department of Labor and Employment, 4/27/2007, pg. 56.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Introduction Page(s): 1.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend, upon ruling out a potentially serious condition, conservative management is provided. If the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary. The clinical documentation submitted for review failed to provide documentation of the specific conservative care that was provided. There was a lack of documentation of MRI or EMG/NCV findings to support the necessity for an epidural steroid injection. Given the above, the request for 1 Referral to a Pain Management Specialist for a Consultation regarding Epidural Steroid Injections for the Cervical Spine is not medically necessary.

PRP Injections treatment for the Cervical Spine: 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 Low Back chapter, Platelet-rich plasma (PRP).

Decision rationale: The Official Disability Guidelines indicate that platelet rich plasma injections are not recommended. The clinical documentation submitted for review failed to provide a rationale for the use of platelet rich plasma injections. Additionally, the request as submitted failed to indicate the quantity of injections being requested. Given the above, the request for PRP Injections treatment for the Cervical Spine is not medically necessary.

1 Prescription of Terocin Patches: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. CharFormat

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate Topicals. Topical Analgesic. Lidocaine Page(s): 105,111,112. Decision based on Non-MTUS Citation dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=100ceb76-8ebe-437b-a8de-37cc76ece9bb.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety "are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed...Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The guidelines indicate that

topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy (tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica)." No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The guidelines recommend treatment with topical salicylates. Per dailymed.nlm.nih.gov, Terocin patches are topical lidocaine and menthol. The clinical documentation submitted for review failed to provide documentation the injured worker had a trial and failure of antidepressants and anticonvulsants. Lidocaine is not recommended except in the form of Lidoderm patches. There was a lack of documentation of exceptional factors. The request as submitted failed to indicate the strength, quantity, and frequency for the requested medication. Given the above, the request for 1 Prescription of Terocin Patches is not medically necessary.

18 Chiropractic treatments: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): 173; 203, 205; 298-300.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58, 59.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines states that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. For the low back, therapy is recommended initially in a therapeutic trial of 6 sessions, and with objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be appropriate. Treatment for flare ups requires a need for re-evaluation of prior treatment success. Treatment is not recommended for the ankle and foot, carpal tunnel syndrome, the forearm, wrist and hand, or the knee. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Treatment beyond 4 to 6 visits should be documented with objective improvement in function. The clinical documentation submitted for review failed to provide documentation of prior treatments. If this was the initial treatment, it would be supported for 6 visits. If this were additional treatment, there was a lack of documentation of objective improvement in function. There was a lack of documentation of the specific body part to be treated per the request. Given the above, and the lack of clarification, the request for 18 Chiropractic treatments is not medically necessary.

18 Acupuncture sessions: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204, Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated and it is

recommended as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. The time to produce functional improvement is 3 to 6 treatments and acupuncture treatments may be extended if functional improvement is documented including either a clinically significant improvement in activities of daily living or a reduction in work restrictions. The clinical documentation submitted for review failed to provide documentation of prior therapies. There was a lack of documentation indicating if this was the initial acupuncture or subsequent acupuncture treatment. If this was the initial request, 6 sessions would be appropriate. If this was for additional acupuncture, there was a lack of documentation of objective functional improvement. The request as submitted failed to indicate the body part to be treated. Given the above, the request for 18 Acupuncture sessions is not medically necessary.

1 Prescription of Deprizine 15mg: 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 NSAIDS, not specifically address Deprizine, however it does address H-2 Blockers Page(s): 69. Decision based on Non-MTUS Citation www.drugs.com/search.php?searchterm=Deprizine.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommends histamine 2 blockers for treatment of dyspepsia secondary to NSAID therapy. The medication Deprizine includes ranitidine, which is a histamine 2 blocker and can be used for the treatment of dyspepsia. However, per Drugs.com, Deprizine: Generic Name: ranitidine hydrochloride, has not been found by FDA to be safe and effective, and this labeling has not been approved by FDA. The use of an oral suspension medication is only supported in the instances when the drug is unavailable in tablet or capsule form or when the patient's condition substantiates their inability to swallow or tolerate a pill. The clinical documentation submitted for review failed to provide documentation the injured worker had an inability to swallow pills or tolerate pills. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. There was a lack of documentation indicating a necessity for nonadherence to the FDA Guidelines. There was a lack of documentation indicating the injured worker had dyspepsia. The request as submitted failed to indicate the frequency and the specific quantity of medication being requested. Given the above, the request for 1 Prescription of Deprizine 15mg is not medically necessary.

Fanatrex (Gabapentin) 25mg: 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 Gabapentin Page(s): 16.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines indicate that gabapentin is used in the treatment of neuropathic pain. Per drugs.com, Fanatrex is an oral suspension of gabapentin that has not approved by the FDA. The use of an oral suspension medication is only supported in the instances when the drug is unavailable in tablet or capsule form or when the patient's condition substantiates their inability to swallow or tolerate a pill. The clinical documentation submitted for review failed to provide documentation of exceptional factors and failed to provide documentation the injured worker had an inability to swallow or tolerate a pill. There was a lack of documentation of exceptional factors to support the use of the medication that has not been approved by the FDA. The request as submitted failed to indicate the frequency and quantity of the medication being requested. Given the above, the request for Fanatrex (Gabapentin) 25mg is not medically necessary.