

<b>Case Number:</b>	CM15-0046743		
<b>Date Assigned:</b>	04/22/2015	<b>Date of Injury:</b>	09/15/2010
<b>Decision Date:</b>	07/23/2015	<b>UR Denial Date:</b>	03/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/11/2015

### 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 31 year old female, who sustained an industrial injury on 09/15/2010. She reported that she felt a pop in her right wrist along with pain and discomfort. There was documentation of other injuries following this injury and included the right wrist, right elbow and right shoulder. According to a progress report dated 02/02/2015, the injured worker complained of sharp right shoulder pain radiating down the arm to the fingers associated with muscle spasms. Pain was rated 7 on a scale of 1-10. She continued to feel pain at the right wrist and thumb. Pain was rated 6. Medications offered her temporary relief of pain and improved her ability to have a restful sleep. Diagnoses included right shoulder joint derangement unspecified, right shoulder pain and status post right carpal tunnel release with residual pain. On 03/02/2015 the injured worker was seen for an Agreed Medical Evaluation. She complained of pain in the right shoulder that radiated down into the right arm and right hand/wrist. There was numbness, tingling and weakness of the right hand. Diagnoses included right upper trapezial muscle group strain with secondary involvement of the right parascapular musculature, mild right wrist de Quervain's syndrome and carpal tunnel syndrome treated surgically 06/07/2014, right carpal tunnel release with median nerve neurolysis. Treatments have included surgery and medications. Currently under review is the request for Synapryn, Tabradol, Deprizine, Dicopanol, Fanatrex, shockwave therapy, acupuncture, Terocin patches and MRI of the right shoulder.

### 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/1ml 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 Page(s): 93-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter-- opioids.

**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 has not been established. Of note, discontinuation of an opioid analgesic requires a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

**1 prescription of Tabradol 1 mg/ml oral suspension: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

**Decision rationale:** Tabradol (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. 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.

**1 prescription of Deprizine 15 mg/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 (Ranitidine) oral suspension is a histamine blocker and antacid used to treat peptic ulcers, gastritis and gastro-esophageal 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 prevent and treat ulcers in the duodenum (where most ulcers develop) and the stomach. 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.

**1 prescription of Dicopanol (diphenhydramine) 5 mg/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 UPTODATE.

**Decision rationale:** Dicopanol, the oral suspension form of 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. Dicopanol 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 was 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 was not established. The requested medication is not medically necessary.

**1 prescription of Fanatrex (Gabapentin) 25 mg/ml oral suspension 420ml: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter--Anti-epilepsy drugs (AEDs).

**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, has not been established. The requested medication is not medically necessary.

### **18 Shockwave therapy sessions for the right shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

**Decision rationale:** As per MTUS/ACOEM Physical modalities, such as massage, diathermy, cutaneous laser treatment, ultrasound treatment, transcutaneous electrical neurostimulation (TENS) units, and biofeedback are not supported by high-quality medical studies, but they may be useful in the initial conservative treatment of acute shoulder symptoms, depending on the experience of local physical therapists available for referral. Some medium quality evidence supports manual physical therapy, ultrasound, and high energy extracorporeal shock wave therapy for calcifying tendinitis of the shoulder. Patients at-home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. Initial use of less-invasive techniques provides an opportunity for the clinician to monitor progress before referral to a specialist. Review of submitted Records indicates that injured worker is complaining of sharp right shoulder pain radiating down the arm to the fingers associated with muscle spasms. As per progress notes in the Medical Records, the injured worker does not appear to have any significant changes in her chronic symptoms, and there is no evidence of calcifying tendinitis. The requested treatment for 18 Shockwave therapy sessions for the right shoulder is not medically necessary and appropriate

### **18 Acupuncture treatments for right shoulder and wrist: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**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. There is evidence that this injured worker has received treatments with acupuncture before, for her right wrist and right shoulder, but there is no documentation of functional improvement that would support continuation of this request. Given the MTUS recommendations for use of acupuncture, the prescription for 18 visits is not medically necessary.

**Unknown prescription of Terocin patches:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medications.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topicals 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 anti-depressants and anti-convulsants 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 treatment is not medically necessary. REF: MTUS Topical Analgesics, pp. 111-113.

**MRI of the Right Shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-9.

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

**Decision rationale:** ODG Shoulder Chapter Magnetic resonance imaging (MRI)As per ODG - criteria for MRI (magnetic resonance imaging): Acute shoulder trauma, suspect rotator cuff

tear/impingement; over age 40; normal plain radiographs: Subacute shoulder pain, suspect instability/labral tear: Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Review of submitted Records indicates that injured worker is complaining of sharp right shoulder pain radiating down the arm to the fingers associated with muscle spasms. As per progress notes in the Medical Records, the injured worker does not appear to have significant changes in symptoms and signs. The records are not clear about neurological findings, and there are no red flags. Without such evidence and based on guidelines cited, the request for MRI Shoulder is not medically necessary and appropriate.

**Unknown periodic UA toxicological evaluation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain Chapter--URINE Drug Testing (UDT).

**Decision rationale:** 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 show the injured worker's prior drug screen results did not indicate substance abuse, noncompliance, or aberrant behavior. This injured worker had multiple drug screens and also had one recently. The treating provider does not provide any documentation about the need for Early Urine Toxicology. Guidelines are not met, therefore, the request is not medically necessary