

Case Number:	CM15-0058637		
Date Assigned:	04/17/2015	Date of Injury:	11/21/2013
Decision Date:	07/08/2015	UR Denial Date:	03/10/2015
Priority:	Standard	Application Received:	03/27/2015

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: Pennsylvania

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 47-year-old female who has reported multifocal pain and mental illness after falling on 11/21/13. The diagnoses have included radiculitis, lumbar disc displacement, herniated nucleus pulposus, hemangioma at L4, low back pain, coccyx fracture, anxiety, depression and insomnia. Treatment has included medications, physical therapy, localized intense neurostimulation therapy (LINT), shockwave therapy, and low back injections. Positional MRIs of the low back region were obtained on 12/23/14 and were compared to those from 6/21/14. Multilevel disk changes were described, not changed from the prior study. The pain management physician, a secondary treating physician, did not describe the neurological changes found in the primary treating physician reports. This physician also referred to prior electrodiagnostic testing but did not provide the date or results. The current primary treating physician has submitted reports from 2013-2015. These reports reflect ongoing "radicular" low back pain that has not improved. None of the many prescribed medications are discussed with respect to the indications and results of use for this specific injured worker. Function is routinely described as poor and the injured worker has remained on "temporarily totally disabled" work status. The medications referred for this Independent Medical Review appear to have been prescribed chronically, for months at least. The signs and symptoms of the injured worker have not changed over the course of treatment and pain levels are unchanged. None of the reports provide an adequate basis for a general surgeon referral. The current treatment requests are listed on the Requests for Authorization from 12/4/14 and 1/23/15. The requests refer to the PR2 of 12/4/14. That PR2 notes ongoing low back pain that is aggravated by even minor activity, paresthasias of the lower extremities, and mental illness. There was low back tenderness, limited range of motion, bilateral sensory deficit in the L4-S1 dermatomes, and 4/5 strength in the lower extremities. The treatment plan included an MRI, Electrodiagnostic testing, Terocin, a long list of unorthodox oral suspensions, ingredients for topical medications, a general surgeon referral

with no listed indications, and a "temporarily totally disabled" work status. On 3/10/15 Utilization Review non-certified the items now appealed for this Independent Medical Review. Note was made of MRIs performed on 6/21/14 and 12/23/14. The requests were referenced to a Request for Authorization of 1/23/15 and a report of 12/4/14. The MTUS, the Official Disability Guidelines, and other guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective EMG/NCV bilateral upper extremities (unknown dos): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 168-171, 182.

Decision rationale: There are no reports from the prescribing physician which adequately present the neurologic findings leading to medical necessity for electrodiagnostic testing. Non-specific pain or paresthesias are not an adequate basis for performance of EMG or NCV. Medical necessity for electrodiagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. The MTUS, per the citations listed above, outlines specific indications for electrodiagnostic testing, and these indications are based on specific clinical findings. The physician should provide a diagnosis that is likely based on clinical findings, and reasons why the test is needed. For example, a diagnosis of radiculopathy should be supported by the signs and symptoms listed in the MTUS cited above. Based on the recent clinical information, there are no specific neurologic symptoms in the upper extremities. This injured worker has had prior electrodiagnostic testing that was not discussed by the treating physician. The treating physician did not adequately address the content of prior testing, treatment, or medical records. It is not clear how long the injured worker has had any upper extremity symptoms and what, if any, kinds of treatment were provided for the neck or upper extremities. Based on the current clinical information, electrodiagnostic testing is not medically necessary, as the treating physician has not provided the specific indications and clinical examination outlined in the MTUS.

Retrospective EMG/NCV bilateral lower extremities (unknown dos): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 309.

Decision rationale: There are no reports from the prescribing physician which adequately present the neurologic findings leading to medical necessity for electrodiagnostic testing. Non-specific pain or paresthesias are not an adequate basis for performance of EMG or NCV. Medical necessity for electrodiagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. The MTUS, per the citations listed above, outlines specific indications for electrodiagnostic testing, and these indications are based on specific clinical findings. The physician should provide a diagnosis that

is likely based on clinical findings, and reasons why the test is needed. For example, a diagnosis of radiculopathy should be supported by the signs and symptoms listed in the MTUS cited above. Based on the recent clinical information, there are no specific neurologic symptoms. The findings are non-specific, and have been present for years. This injured worker has had prior electrodiagnostic testing and imaging that was not discussed by the treating physician. The treating physician did not adequately address the content of prior testing, treatment, or medical records. Based on the current clinical information, electrodiagnostic testing is not medically necessary, as the treating physician has not provided the specific indications, clinical examination, and sufficient review of prior treatment as outlined in the MTUS.

Retrospective Capsaicin 0.025%, Flurbiprofen 15%, Gabapentin 10%, Menthol 2%, Camphor 2%, 180grams (unknown dos): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain, Topical Medications Page(s): 60, 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Topical analgesics.

Decision rationale: The treating physician has not discussed the ingredients of this topical agent and the specific indications for this injured worker. Per the MTUS page 60, 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. In addition to any other reason for lack of medical necessity for this topical agent prescribed along with many other medications, it is not medically necessary on this basis at minimum. The Official Disability Guidelines state that Custom compounding and dispensing of combinations of medicines that have never been studied is not recommended, as there is no evidence to support their use and there is potential for harm. The compounded topical agent in this case is not supported by good medical evidence and is not medically necessary based on this Official Disability Guidelines recommendation. The MTUS states that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Per the MTUS citation, there is no good evidence in support of topical gabapentin; this agent is not recommended. The treating physician did not provide any indications or body part intended for this NSAID. Note that topical flurbiprofen is not FDA approved, and is therefore experimental and cannot be presumed as safe and efficacious. Non-FDA approved medications are not medically necessary. Capsaicin has some indications, in the standard formulations readily available without custom compounding. It is not clear what the indication is in this case, as the injured worker does not appear to have the necessary indications per the MTUS. The MTUS also states that capsaicin is only recommended when other treatments have failed. This injured worker has not received adequate trials of other, more conventional treatments. The treating physician did not discuss the failure of other, adequate trials of other treatments. Capsaicin is not medically necessary based on the lack of indications per the MTUS. Menthol and camphor are not discussed specifically in the MTUS. The topical compounded medication prescribed for this injured worker is not medically necessary based on the MTUS, the Official Disability Guidelines, lack of medical evidence, and lack of FDA approval.

Retrospective Cyclobenzaprine 2%, Flurbiprofen 25% 180grams (unknown dos): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain, Topical Medications Page(s): 60, 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Topical analgesics.

Decision rationale: The treating physician has not discussed the ingredients of this topical agent and the specific indications for this injured worker. Per the MTUS page 60, 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. In addition to any other reason for lack of medical necessity for these topical agents, they are not medically necessary on this basis at minimum. The Official Disability Guidelines state that "Custom compounding and dispensing of combinations of medicines that have never been studied is not recommended, as there is no evidence to support their use and there is potential for harm. " The compounded topical agent in this case is not supported by good medical evidence and is not medically necessary based on this Official Disability Guidelines recommendation. The MTUS states that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Per the MTUS citation, there is no good evidence in support of topical muscle relaxants; these agents are not recommended. Two topical NSAIDs (two topicals with flurbiprofen) were dispensed simultaneously which is duplicative and unnecessary, as well as possibly toxic. The treating physician did not provide any indications or body part intended for this NSAID. Note that topical flurbiprofen is not FDA approved, and is therefore experimental and cannot be presumed as safe and efficacious. Non-FDA approved medications are not medically necessary. The topical compounded medication prescribed for this injured worker is not medically necessary based on the MTUS, the Official Disability Guidelines, lack of medical evidence, and lack of FDA approval.

Retrospective MRI lumbar spine (unknown dos): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 290-296, 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter, MRI; Standing MRI.

Decision rationale: For the purposes of this review, the MRI appeal was for the MRI requested in the report of 12/4/14. The treating physician has not described the clinical evidence of significant pathology discussed in the MTUS, such as "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination. " No "red flag" conditions are identified. The treating physician has not provided an adequate clinical evaluation, as outlined in the MTUS ACOEM Guidelines Pages 291-296. Per the Official Disability Guidelines citation above, imaging for low back pain is not beneficial in the absence of specific signs of serious pathology. Repeat imaging should be based on the presence of new symptoms and signs. The treating physician has not provided specific indications for performing an MRI. There are no significant changes clinically since the last MRI. The current clinical exam is unchanged from at least 2013. Repeat MRI may be indicated if there were to be significant worsening as evidenced by specific signs and symptoms suggesting new low back pathology. The MRI requested appears to be a positional or dynamic MRI, which is not recommended in the guidelines cited above. An MRI of the lumbar spine is not indicated in light of the paucity of clinical findings suggesting any serious pathology; increased or ongoing pain, with or without radiation, is not in itself an indication for MRI. An MRI of the lumbar spine is not medically

necessary based on lack of sufficient indications per the MTUS and the Official Disability Guidelines.

Retrospective MRI sacrum and coccyx (unknown dos): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 290-296, 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter, MRI; Standing MRI.

Decision rationale: For the purposes of this review, the MRI appeal was for the MRI requested in the report of 12/4/14. The treating physician has not described the clinical evidence of significant pathology discussed in the MTUS, such as "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination. " No "red flag" conditions are identified. The treating physician has not provided an adequate clinical evaluation, as outlined in the MTUS ACOEM Guidelines Pages 291-296. Per the Official Disability Guidelines citation above, imaging for low back pain is not beneficial in the absence of specific signs of serious pathology. Repeat imaging should be based on the presence of new symptoms and signs. The treating physician has not provided specific indications for performing an MRI. There are no significant changes clinically since the last MRI. The current clinical exam is unchanged from at least 2013. Repeat MRI may be indicated if there were to be significant worsening as evidenced by specific signs and symptoms suggesting new low back pathology. MRI of the sacrum and coccyx is not indicated in light of the paucity of clinical findings suggesting any serious pathology; increased or ongoing pain, with or without radiation, is not in itself an indication for MRI. An MRI of the sacrum and coccyx is not medically necessary based on lack of sufficient indications per the MTUS and the Official Disability Guidelines.

Retrospective Deprizine (no strength or quantity provided) (unknown dos): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: Deprizine is ranitidine in an oral suspension. Ranitidine is prescribed without any patient-specific rationale provided. If ranitidine is prescribed as cotherapy with an NSAID, ranitidine is not the best drug. Note the MTUS recommendations cited. There are no medical reports which adequately describe the relevant signs and symptoms of possible GI disease. There is no examination of the abdomen on record. There are many possible etiologies for GI symptoms; the available reports do not provide adequate consideration of these possibilities. Empiric treatment after minimal evaluation is not indicated. Cotherapy 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. The requested prescription is for an unstated quantity and dose. Requests for unspecified quantities of medications are not medically necessary, as the quantity may potentially be excessive and in use for longer than recommended. Ranitidine is not medically necessary based on the MTUS.

Retrospective Dicopanol (no strength or quantity provided) (unknown dos): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.nlm.nih.gov.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Official Disability Guidelines, Pain chapter, Insomnia.

Decision rationale: The treating physician has stated that Dicopanol is diphenhydramine and other unnamed 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. The MTUS does not address the use of hypnotics other than benzodiazepines. 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. Note the Official Disability Guidelines citation above. That citation also states that antihistamines are not indicated for long term use as tolerance develops quickly, and that there are many, significant side effects. The requested prescription is for an unstated quantity and dose. Requests for unspecified quantities of medications are not medically necessary, as the quantity may potentially be excessive and in use for longer than recommended. Dicopanol is not medically necessary based on lack of a sufficient analysis of the patient's condition, the ODG citation, and lack of information provided about the ingredients.

Retrospective Fanatrex (no strength or quantity provided) (unknown dos): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin, Gabarone, generic available). *CharFormat

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs Page(s): 16-22.

Decision rationale: Fanatrex is stated to be a formulation of gabapentin. The treating physician has stated that it is for neuropathic pain. None of the physician reports adequately discuss the signs and symptoms diagnostic of neuropathic pain. There are no physician reports which adequately address the specific symptomatic and functional benefit from the antiepileptic drugs (AEDs) used to date. Note the criteria for a "good" response per the MTUS. The requested prescription is for an unstated quantity and dose. Requests for unspecified quantities of medications are not medically necessary, as the quantity may potentially be excessive and in use for longer than recommended. Gabapentin is not medically necessary based on the lack of any clear indication, and the lack of significant symptomatic and functional benefit from its use to date.

Retrospective Synapryn (no strength or quantity provided) (unknown dos): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Glucosamine (and Chondroitin Sulfate Page(s): 77-80, 50.

Decision rationale: Synapryn is tramadol with glucosamine in an oral suspension: 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 illogical and 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 osteoarthritis, 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. The treating physician did not provide good evidence of knee osteoarthritis. 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. The requested prescription is for an unstated quantity and dose. Requests for unspecified quantities of medications are not medically necessary, as the quantity may potentially be excessive and in use for longer than recommended. 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.

Retrospective Tabradol (no strength or quantity provided) (unknown dos): 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): 63-66.

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. The requested prescription is for an unstated quantity and dose. Requests for unspecified quantities of medications are not medically necessary, as the quantity may potentially be excessive and in use for longer than recommended. Per the MTUS, cyclobenzaprine is not indicated and is not medically necessary.

Retrospective Terocin patches (no strength or quantity provided) (unknown dos): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: UpToDate: camphor and menthol: drug information. In UpToDate, edited by Ted. W. Post, published by UpToDate in Waltham, MA, 2015.

Decision rationale: Per the MTUS, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. If any compounded product contains at least one drug or drug class that is not recommended, the compounded product is not recommended. Terocin patch contains lidocaine and menthol. The site of application and directions for use were not specified. Lidocaine is only FDA approved for treating post-herpetic neuralgia, and the dermal patch form (Lidoderm) is the only form indicated for neuropathic pain. There is no documentation that this injured worker has neuropathic pain or post-herpetic neuralgia. The MTUS and ODG are silent with regard to menthol. It may be used for relief of dry, itchy skin. This agent carries warnings that it may cause serious burns. The requested prescription is for an unstated quantity; an unspecified quantity and duration can imply a potentially unlimited duration and quantity, which is not medically necessary or indicated. Due to lack of indication, the request for Terocin patches is not medically necessary.

Retrospective general surgeon referral (unknown dos): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7 Independent Medical Examinations and Consultations, pages 127.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 23-33.

Decision rationale: There is not enough information presented to show medical necessity for this referral. There is an insufficient accounting of the relevant signs and symptoms. The ACOEM Guidelines, pages 23-33, provide recommendations for evaluating musculoskeletal and other medical conditions, including pertinent history and physical findings. The treating physician has not provided an evaluation in accordance with this section of the MTUS. Medical necessity for any referral, test or treatment should be supportable from the available reports. Necessary information should include the relevant signs and symptoms, including the duration of symptoms, other relevant medical history, aggravating and relieving factors, and circumstances of onset. A basic physical exam should be included. In this case, this kind of information is not presented and the reason for this referral is unclear. For these reasons, the referral is not medical necessary.