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| <b>Case Number:</b>   | CM14-0026490 |                              |            |
| <b>Date Assigned:</b> | 06/16/2014   | <b>Date of Injury:</b>       | 03/02/2013 |
| <b>Decision Date:</b> | 08/15/2014   | <b>UR Denial Date:</b>       | 02/16/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 03/03/2014 |

### 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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 25 year old female who was injured on March 2, 2013 while she was sitting on a rolling office chair when one of the wheels on the chair released and came off while she was reaching for a phone causing the chair to flip back and the patient fell back and hit her head, neck and shoulder on the concrete floor and the back of the chair. She lost consciousness and when she woke up she was being transported by ambulance to the hospital. Prior treatment history has included the following medications: tramadol, metaxalone, prednisone, omeprazole, and hydrocodone. Diagnostic studies reviewed include urine drug screen dated December 10 and 17, 2013, the results were negative for prescribed medication naproxen. Progress report dated January 7, 2014 documented the patient with complaints of headache, burning radicular neck pain radiating to the shoulders and arms, constant moderate to severe with pain rated 6-7/10, associated with numbness and tingling of the bilateral upper extremities. She has burning radicular low back pain radiating to the leg and rated 5-6/10 on the pain scale, which is constant moderate to severe associated with numbness and tingling of the bilateral lower extremities. The patient states that the symptoms persist but the medications do offer her temporary relief of pain and improve her ability to have restful sleep. She denies any problems with the medications and the pain is also aggravated by activity. Objective findings on examination include cranial nerves II through XII intact. Examination of the cervical spine reveals tenderness in the suboccipital region, trapezius and scalene muscles. The range of motion is decreased with motion. Sensation is decreased bilaterally and motor strength is decreased bilaterally. Examination of the lumbar spine reveals the patient heel-toe walks with pain. She squats to 50% and lacks 6 inches to the ground. Tender lumbar paraspinal muscles and lumbosacral junction. There is decreased range of motion. Straight leg raise is positive at 40 degrees. Sensation is decreased bilaterally as well as motor strength decreased bilaterally. Treatment Plan: A request for MRI of the cervical and

lumbar spine. Medications were prescribed. Physical therapy for lumbar and cervical spine with acupuncture and shockwave therapy and follow up in four weeks. Utilization report dated February 16, 2014 did not certify any of the specific treatment plan requested. The request for cyclophene 5% gel was not certified, as there was no evidence based guideline to support cyclophene as a topical medications and is not recommended for topical use. The request for Synapryn, Tabradol, deprizine, dicopanol, and Fanatrex was not certified because there were no indications as to why the patient would require oral suspension medication as compared to tablet form. The request for unknown physical therapy visits was not certified because there was information requested from the provider and at the time of the review the information was pending. The request will be reconsidered upon receipt of the information requested. The request for acupuncture was certified with modification, as there was no indication of previous acupuncture therapy so it was modified up to 6 sessions and non-certification of any additional sessions. The request for shockwave therapy was not certified, as there were no evidence-based guidelines to support extracorporeal shockwave therapy for cervical or lumbar complaints or for any condition that the patient presents with. The request for Ketoprofen was not certified, as it is not approved for topical application. The request for a urine drug screen was not certified because there were no indications for a repeat test to be performed at such a short interval.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Cyclophene 5% gel, 120 grams:** Upheld

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

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

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The medical records document the patient was diagnosed with post concussion syndrome, cervical spine sprain/strain with radiculopathy, lumbar spine sprain/ strain with radiculopathy, and posttraumatic headache. This is a request for topical Cyclobenzaprine. However, topical muscle relaxants are not recommended by the Chronic Pain Medical Treatment Guidelines. The request for Cyclophene 5% gel, 120 grams, is not medically necessary or appropriate.

**Synapryn 10mg/1ml, 500ml:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Opioids specific drug list Page(s): 82-83, 93-94.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, opioids are recommended in chronic back pain for relief of breakthrough pain if there is documented functional improvement. The medical records document the patient was diagnosed with post concussion syndrome, cervical spine sprain/strain with radiculopathy, lumbar spine sprain/strain with radiculopathy, and posttraumatic headache. The patient has been prescribed tramadol since 6/62013. Medical records fail to establish functional improvement or pain reduction due to use of tramadol or other medications. The need for an oral suspension is not established. The request for Synapryn 10mg/1ml, 500ML, is not medically necessary or appropriate.

**Tabradol 1vmg/ml, 250ml:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine is recommended as an option, using a short course of therapy. The addition of Cyclobenzaprine to other agents is not recommended. The medical records document the patient was diagnosed with post concussion syndrome, cervical spine sprain/strain with radiculopathy, lumbar spine sprain/ strain with radiculopathy, and posttraumatic headache. The patient has chronic pain. Cyclobenzaprine was prescribed early in the course of the patient's treatment without documented functional improvement. Further, there is no documentation of acute exacerbation, and long-term use of Cyclobenzaprine is not recommended. Finally, the need for an oral suspension is not established. The request for Tabradol 1vmg/ml, 250ml, is not medically necessary or appropriate.

**Deprizine 15mg/ml, 250 ml:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68-69.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, H2-receptor antagonists are recommended in the treatment of dyspepsia that is secondary to NSAID therapy. The medical records document the patient was diagnosed with post concussion syndrome, cervical spine sprain/strain with radiculopathy, lumbar spine sprain/ strain with radiculopathy, and posttraumatic headache. This is a request for Deprizine, an antihistamine. However, it is not clear that the patient has GI symptoms secondary to NSAID use. The patient is not documented to be at intermediate or high risk of GI complications due to NSAID use. The need for an oral suspension is not established. The request for Deprizine 15mg/ml, 250 ml, is not medically necessary or appropriate.

**Dicopanol 5mg/ml, 150ml:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness & Stress, Insomnia treatment.

**Decision rationale:** The CA MTUS guidelines have not addressed the issue of the dispute. According to the ODG, sedating antihistamines (primarily over the counter medications) are recommended for treatment of insomnia. However, tolerance seems to develop within few days. Next-day sedation as well as impaired psychomotor and cognitive function has been noted. The medical records document the patient was diagnosed with post concussion syndrome, cervical spine sprain/strain with radiculopathy, lumbar spine sprain/ strain with radiculopathy, and posttraumatic headache. A diagnosis of insomnia is not clearly established by the provided medical records. The need for an oral suspension is not established. The request for Dicopanol 5mg/ml, 150ml, is not medically necessary or appropriate.

**Fanatrex 25mg/ml, 420ml:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDs) Page(s): 16-19.

**Decision rationale:** According to the CA MTUS guidelines, antiepilepsy drugs are recommended for neuropathic pain. The medical records document the patient was diagnosed with post concussion syndrome, cervical spine sprain/strain with radiculopathy, lumbar spine sprain/ strain with radiculopathy, and posttraumatic headache. This is a request for an oral suspension of Gabapentin. However, while the patient has radicular complaints, physical examination findings are inconsistent, and are not supported by diagnostic findings. Further, the need for an oral suspension is not established. Medical necessity is not established.

**Ketoprofen 20%, 120 grams:** Upheld

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

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

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, topical NSAIDs (non-steroidal anti-inflammatory drugs) may be recommended for osteoarthritis. However, Ketoprofen is not currently FDA-approved for topical application as it has an

extremely high incidence of photo contact dermatitis. Further, topical NSAIDs are not recommended for the neck or low back, and the patient does not have documented osteoarthritis. The request for Ketoprofen 20%, 120 grams, is not medically necessary or appropriate.

**Unknown number of physical therapy visits:** 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 Physical Medicine Page(s): 98-99.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, physical medicine is recommended to control symptoms such as pain, inflammation and swelling, and to improve the rate of healing soft tissue injuries. For an acute exacerbation of chronic pain with neuralgia, neuritis and radiculitis, guidelines recommend eight to ten sessions over four weeks. The medical records document the patient was diagnosed with post concussion syndrome, cervical spine sprain/strain with radiculopathy, lumbar spine sprain/ strain with radiculopathy, and post traumatic headache. This is a request for physical therapy, but the number of sessions and body parts are not specified. Further, the patient underwent physical therapy during the initial stages of her treatment without documentation of functional improvement. There is no documentation of acute exacerbation which might justify additional treatments. The request for an unknown number of physical therapy visits is not medically necessary or appropriate.

**Unknown number of acupuncture sessions:** Upheld

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

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

**Decision rationale:** According to the Acupuncture Medical Treatment Guidelines, acupuncture is recommended 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. The medical records document the patient was diagnosed with post concussion syndrome, cervical spine sprain/strain with radiculopathy, lumbar spine sprain/ strain with radiculopathy, and post traumatic headache. This is a request for acupuncture. However, the number of visits is not requested. No specific rationale is provided. The request for an unknown number of acupuncture sessions is not medically necessary or appropriate.

**Unknown number of shockwave therapy sessions:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 598. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Extracorporeal shock wave therapy (ESWT).

**Decision rationale:** According to the Elbow Disorders Chapter of the American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines, extracorporeal shock wave therapy (ESWT) is not recommended. According to the ODG, the request for ESWT is recommended for calcifying tendinitis of shoulder joint. The medical records document the patient was diagnosed with post concussion syndrome, cervical spine sprain/strain with radiculopathy, lumbar spine sprain/ strain with radiculopathy, and post traumatic headache. The request for unknown number of shockwave therapy sessions is not medically necessary or appropriate.

**One urine drug screen:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, drug testing is an option, using a urine drug screen to assess for the use or the presence of illegal drugs. The medical records document the patient was diagnosed with post concussion syndrome, cervical spine sprain/strain with radiculopathy, lumbar spine sprain/ strain with radiculopathy, and post traumatic headache. This is a request for a repeat urine drug screen. However, urine drug screens were done December 10 and 17, 2013 without apparent abnormalities. There is no documentation of high risk of abuse or aberrant behavior that would warrant drug screen testing on a more than semiannual basis. The request for one urine drug screen is not medically necessary or appropriate.