

<b>Case Number:</b>	CM14-0214800		
<b>Date Assigned:</b>	02/09/2015	<b>Date of Injury:</b>	11/15/2012
<b>Decision Date:</b>	06/08/2015	<b>UR Denial Date:</b>	12/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/23/2014

### 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. 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 52 year old female who has reported widespread pain after an injury on 11/15/12. Diagnoses have included cervicgia, cervical spine radiculopathy, cervical disc displacement, left shoulder pain, left shoulder acromioclavicular arthrosis, left shoulder tendonitis, shoulder internal derangement, left wrist tenosynovitis, left wrist ganglion cyst, thoracic spine pain, thoracic disc displacement, Schmorl's nodes, lumbosacral pain, lumbar spine radiculopathy, lumbar disc displacement, abdominal discomfort, anxiety disorder, mood disorder, and sleep disorder. Treatment has included chiropractic, medications, physical therapy, acupuncture, shockwave therapy, and injections. The treating physician reports during 2014 show ongoing prescribing of the medications now under Independent Medical Review as well as shockwave therapy for the neck and back, physical therapy visits, and "temporarily totally disabled" work status. Reports from the treating physician over the course of 2014 do not address the patient-specific indications or results for any medication. The injured worker continued to have ongoing pain and was stated to be "temporarily totally disabled". No medications were prescribed individually, one at a time, and given a trial period to assess results. Medications were prescribed together with no individual assessment. It appears that the currently requested medications are those which have been given chronically. None of the reports address the specific results of physical therapy. Attached to the reports were generic information statements about the various medications, tests, and therapies, with no patient-specific information. On 6/30/14, 8/19/14 and 9/16/14 12 visits of physical therapy for the neck and back were prescribed. Per a physical therapy report of 10/16/14, 42 visits of physical therapy had been

attended. There were brief references to non-specific improvements in function. Urine drug screens on 8/19/14, 9/16/14 and 11/21/14 were negative for tramadol. On 12/9/14 Utilization Review non-certified physical therapy, localized intense neurostimulation therapy (LINT), shockwave therapy, and many medications. The MTUS and the Official Disability Guidelines were cited.

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

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

#### **18 Physical therapy visits for the cervical & lumbar spine between 10/24/2010 and 1/15/2015: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Introduction, functional improvement, Physical Medicine Page(s): 9, 98-99.

**Decision rationale:** Per the MTUS, Chronic Pain section, functional improvement is the goal rather than the elimination of pain. The maximum recommended quantity of Physical Medicine visits is 10, with progression to home exercise. The treating physician has not stated a purpose for the current physical therapy prescription. It is not clear what is intended to be accomplished with this physical therapy, given that it will not cure the pain and there are no other goals of therapy. The current physical therapy prescription exceeds the quantity recommended in the MTUS. This injured worker has already completed a course of Physical Medicine (42 visits) which greatly exceeds the quantity of visits recommended in the MTUS. No medical reports identify specific functional deficits, or functional expectations for further Physical Medicine. The Physical Medicine prescription is not sufficiently specific, and does not adequately focus on functional improvement. There is no evidence of functional improvement after the physical therapy to date. Total disability work status implies a complete lack of functional improvement. Given the completely non-specific prescription for physical therapy in this case, it is presumed that the therapy will use or even rely on passive modalities. Note that the MTUS recommends against therapeutic ultrasound and passive modalities for treating chronic pain. Additional Physical Medicine is not medically necessary based on the MTUS, lack of sufficient emphasis on functional improvement, and the failure of Physical Medicine to date to result in functional improvement as defined in the MTUS.

#### **1 localized intense neurostimulation therapy (LINT) for the lumbar spine between 10/24/2014 and 1/15/2015: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

**Decision rationale:** The MTUS does not address LINT. Per the ODG, hyperstimulation analgesia is not recommended until there are higher quality studies. Localized manual high-intensity neurostimulation devices are applied to small surface areas to stimulate peripheral nerve endings, thus causing the release of endogenous endorphins. The procedure requires impedance mapping of the back. Initial results are promising, but only from two low quality studies sponsored by the manufacturer. The Official Disability Guidelines recommend against these procedures based on the lack of medical evidence. The LINT is therefore not medically necessary.

**6 Shockwave therapy treatments for the cervical & lumbar spine 10/24/2014 and 1/15/2015:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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 chapter, Shock wave therapy.

**Decision rationale:** The MTUS does not provide direction for shock wave therapy for low back or neck pain. The Official Disability Guidelines cited above recommend against this therapy. The available evidence does not support the effectiveness of ultrasound or shock wave for treating low back pain. It is therefore not medically necessary. The MTUS and the Official Disability Guidelines do not comment on shockwave therapy for the neck but this request is not medically necessary based on the lumbar component of the request.

**1 prescription foe Terocin patches between 10/24/2014 and 1/15/2015:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain, Topical Analgesics Page(s): 60, 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:** The treating physician has not discussed the ingredients of Terocin and the specific indications for this injured worker. Terocin patch contains lidocaine and menthol. Per page 60 of the MTUS, medications should be trialed one at a time. Regardless of any specific medication contraindications for this patient, the MTUS recommends against starting multiple medications simultaneously. Per the MTUS, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Per the MTUS, any compounded product that contains at least one drug that is not recommended is not recommended. 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 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. Due to lack of indication, the request for Terocin patches is not medically necessary.

**2 Prescription Tabradol 1 mg/ml oral suspension - 250 ml between 10/24/2015 and 1/15/2015: 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. 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. Prescribing was not for a short term exacerbation. Multiple medications were prescribed together without adequate trials of each. Per the MTUS, cyclobenzaprine is not indicated and is not medically necessary.

**1 Prescription Deprizine 15mg/ml oral suspension - 250 ml between 10/24/2014 and 1/15/2015: 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, 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 gastrointestinal (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. Ranitidine is not medically necessary based on the MTUS.

**1 Prescription Dicopanol 5 mg/ ml oral suspension - 150 ml between 10/24/2014 and 1/15/2015: 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 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. 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.

**1 Prescription Fanatrex (gabapentin) 25 mg/ml oral suspension- 420 ml between 10/24/2014 and 1/15/2015: 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 Page(s): 16-21.

**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. 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.

**1 Follow up in 4 weeks between 10/24/2014 and 1/15/2015: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines functional restoration approach to chronic pain management Page(s): 7-8.

**Decision rationale:** The MTUS, per the citation above, discusses the indications for medications to treat chronic pain and the variables that should be considered. There is no discussion by the treating physician of an approach based on functional improvement. The medication prescribing that has occurred in this case has been far outside of the recommendations of the MTUS and the FDA and should not be continued. The other treatments prescribed (LINT and shockwave therapy) are not supported by good medical evidence and guidelines, as noted above. The follow-up visit is presumed to be for the purpose of continuing treatments which are not supported by the MTUS and other guidelines and is therefore not medically necessary.