

Case Number:	CM15-0011134		
Date Assigned:	01/29/2015	Date of Injury:	05/28/2014
Decision Date:	06/16/2015	UR Denial Date:	01/09/2015
Priority:	Standard	Application Received:	01/21/2015

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: Emergency 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 55-year-old male who has reported shoulder pain after a pulling injury on 5/28/2014. Diagnoses include right shoulder sprain/strain and rule out right shoulder rotator cuff tear. An MRI on 7/29/14 showed degenerative changes. Medical care to date has included an MRI, a contrast MRI on 10/17/14, injections, medications, shock wave therapy, physical therapy and acupuncture. The current primary treating physician has been seeing this injured worker since 10/18/14. At the initial visit there was a brief history given of a shoulder injury treated with physical therapy, medications, and an MRI. No further details were given. There was ongoing shoulder pain, which radiated to the hand. The current medications for pain were not named or discussed. There was regional shoulder pain. There was global hypesthesia in the upper extremity and 4/5 strength in the upper extremities. A long list of unconventional medications was prescribed. The treatment plan also included a urine drug screen, radiographs, TENS, physical therapy, acupuncture, shockwave therapy, MRI, electro diagnostic testing, and Terocin. There was no discussion of the results of prior tests or treatment. Patient specific indications for the treatment were absent. The work status was temporarily totally disabled. Per the PR2 of 11/15/2014 there was ongoing shoulder pain helped by unspecified medications. The physical examination was unchanged. The plan of care included the same items from the last visit as well as PRP injections. As before, the patient specific indications for the treatments were lacking. There was no discussion of the results of using any medications or other treatment. On 1/9/15 Utilization Review non-certified the treatments and tests that have been referred for an Independent Medical Review. The MTUS and the Official Disability Guidelines were cited. The

Utilization Review noted prior courses of physical therapy prescribed by the initial treating physician and an orthopedic surgeon.

IMR ISSUES, DECISIONS AND RATIONALES

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

Compounded Ketoprofen Cream 20%, 165 grams: Upheld

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

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

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines topical Analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Guidelines also state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical ketoprofen is not FDA approved, and is not recommended per the MTUS citation above. Therefore, the request is not medically necessary based on the MTUS.

Compounded Cyclobenzaprine 5% Cream, 100 grams: Upheld

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

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

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines topical Analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Guidelines also state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Per the MTUS citation above, there is no good evidence in support of topical muscle relaxants; these agents are not recommended. In addition, two muscle relaxants were dispensed simultaneously (two forms of cyclobenzaprine), which is duplicative, unnecessary, and potentially toxic. Therefore, the request is not medically necessary based on the MTUS.

Synapryn 10/mg/1ml Oral Suspension 500ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol, Glucosamine Page(s): 84, 50.

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 evidence for knee osteoarthritis. In addition, 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 that are habituating. 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.

Tabradol 1mg/1ml Oral Suspension 250 ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, Muscle Relaxants Page(s): 41, 63.

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

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 shoulder pain, not back pain, with no evidence of prescribing for flare-ups and no evidence of a condition for which muscle relaxants are indicated. 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. Per the MTUS, cyclobenzaprine is not indicated and is not medically necessary.

Deprizine 15mg/ml Oral Suspension 250 ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs and Proton Pump Inhibitor Page(s): 68.

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

Dicopanor 5mg/ml Oral Suspension 150 ml: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines web version, Pain section - Insomnia treatment.

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, Insomnia.

Decision rationale: The treating physician has stated that Dicopanor 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. Dicopanor is not medically necessary on this basis alone. In addition, Dicopanor 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. Dicopanor 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.

Fanatrex 25mg/1ml Oral Suspension 420 ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drug Page(s): 17.

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 discusses the signs and symptoms diagnostic of neuropathic pain. There is no evidence of any benefit from use to date. Gabapentin is not medically necessary based on the lack of any clear indication and the lack of benefit.

Terocin Patches #3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine Indication Page(s): 112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, Topical Analgesics Page(s): 60, 111-113.

Decision rationale: The treating physician has not discussed the ingredients of Terocin and the specific indications for this injured worker. Per the manufacturer, Terocin is Methyl Salicylate 25%, Menthol 10%, Capsaicin 0.025%, Lidocaine 2.5%, Aloe, Borage Oil, Boswellia Serrata, and other inactive ingredients. 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 3-7 medications simultaneously. Per the MTUS, any compounded product that contains at least one drug that is not recommended, is not recommended. Boswellia Serrata resin and topical lidocaine other than Lidoderm are not recommended per the MTUS. Capsaicin alone in the standard formulation readily available OTC may be indicated for some patients. The indication in this case is unknown, as the patient has not failed adequate trials of other treatments. Capsaicin is also available OTC, and the reason for compounding the formula you have prescribed is not clear. Terocin is not medically necessary based on lack of specific medical indications, the MTUS, lack of medical evidence, FDA directives, and inappropriate prescribing.

Platelet Rich Plasma Injection for the Right Shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines web: Shoulder Platelet-rich plasma (PRP).

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

Decision rationale: The MTUS does not provide direction for the use of platelet-rich plasma (PRP). The Official Disability Guidelines, Shoulder chapter, classify this treatment as under study, and recommend it only as an option in conjunction with arthroscopic repair for large to massive rotator cuff tears. The proposed diagnoses in this case are not those discussed in the guidelines for which there might be benefit. The PRP injection is not medically necessary based on lack of sufficient medical evidence and the cited guideline.

Physical Therapy for the Right Shoulder (18-sessions): Upheld

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

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, which likely meets or exceeds the quantity of visits recommended in the MTUS. The treating physician did not address the results of the prior physical therapy and reasons why additional physical therapy is necessary. There is no evidence of functional improvement from prior physical therapy. Total disability work status implies a likely lack of ability to attend physical therapy, as the injured worker is incapable of performing any and all work activity, even very light activity such as sitting, standing, and walking. Temporarily totally disabled status is not an appropriate baseline for initiation of a physical therapy program emphasizing functional improvement. Total disability work status implies a complete lack of functional improvement. 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.

Acupuncture Therapy for the Right Shoulder (18-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: 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. The treating physician has not provided the specific indications for acupuncture as listed in the MTUS. There is no discussion of issues with pain medications, or functional recovery in conjunction with surgery and physical rehabilitation. An initial course of acupuncture is 3-6 visits per the MTUS. The prescription is for 18 visits, which exceeds the quantity recommended in the MTUS. Given that the focus of acupuncture is functional improvement, function (including work status or equivalent) must be addressed as a starting point for therapy and as a measure of progress. As discussed in the MTUS, chronic pain section, the goal of all treatment for chronic pain is functional improvement, in part because chronic pain cannot be cured. Temporarily totally disabled work status is evidence of a lack of focus on functional improvement. An initial course of acupuncture is not medically necessary

based on a prescription, which exceeds the quantity recommended in the MTUS, and lack of specific indications per the MTUS.

MRI of the Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209, 200.

Decision rationale: The MTUS-ACOEM Guidelines, pages 207-9, discuss the criteria for imaging of the shoulder. Special studies are not needed unless there has been a 4-6 week period of conservative care. Exceptions to this rule include the specific bony pathology listed on page 207, and neurovascular compression. Page 200 of the ACOEM Guidelines describes the components of the clinical evaluation of the shoulder. The necessary components of the shoulder examination described in the MTUS are not present. The available reports do not adequately explain the kinds of conservative care already performed. The treating physician has not addressed the prior shoulder MRI and arthrogram, and reasons why the MRI should be repeated. The MRI is not medically necessary based on the MTUS recommendations and lack of necessity to repeat the test.

Electromyography of the Right Upper Extremity: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 196-201, 213.

Decision rationale: There are no reports from the prescribing physician, which adequately present the neurologic findings leading to medical necessity for electro diagnostic testing. Non-specific pain or paresthesias are not an adequate basis for performance of EMG or NCV. Medical necessity for electro diagnostic 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 electro diagnostic 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 clinical findings are non-specific and regional, which are very unlikely to represent significant neurological pathology. 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. The MTUS recommends against electro diagnostic testing for practically all shoulder conditions, including the diagnoses present in this case. Based on the current clinical information, electro diagnostic testing is not medically necessary, as the treating

physician has not provided the specific indications and clinical examination outlined in the MTUS.

Electromyography of the Left Upper Extremity: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 196-201, 213.

Decision rationale: There are no reports from the prescribing physician, which adequately present the neurologic findings leading to medical necessity for electro diagnostic testing. Non-specific pain or paresthesias are not an adequate basis for performance of EMG or NCV. Medical necessity for electro diagnostic 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 electro diagnostic 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 clinical findings are non-specific and regional, which are very unlikely to represent significant neurological pathology. 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. The MTUS recommends against electro diagnostic testing for practically all shoulder conditions, including the diagnoses present in this case. Based on the current clinical information, electro diagnostic testing is not medically necessary, as the treating physician has not provided the specific indications and clinical examination outlined in the MTUS.

Nerve Conduction Velocity of the Right Upper Extremity: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 196-201, 213.

Decision rationale: There are no reports from the prescribing physician, which adequately present the neurologic findings leading to medical necessity for electro diagnostic testing. Non-specific pain or paresthesias are not an adequate basis for performance of EMG or NCV. Medical necessity for electro diagnostic 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 electro diagnostic 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 clinical findings are non-specific and regional, which are very unlikely to represent significant neurological pathology. 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. The MTUS recommends against electro diagnostic testing for practically all shoulder conditions, including the diagnoses present in this case. Based on the current clinical information, electro diagnostic testing is not medically necessary, as the treating physician has not provided the specific indications and clinical examination outlined in the MTUS.