

Case Number:	CM15-0117974		
Date Assigned:	06/29/2015	Date of Injury:	03/08/2014
Decision Date:	10/12/2015	UR Denial Date:	05/28/2015
Priority:	Standard	Application Received:	06/18/2015

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, Tennessee

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 18 year old (), female who sustained a work related injury on 3/8/14. She was returning a box of fries in the freezer when someone blocked the door. As she tried to get the door open, the box slipped and to prevent it from falling, she caught the box in midair causing instant pain in her back. The diagnoses have included thoracic spine sprain/strain, thoracic spine pain, lumbar spine sprain/strain, lumbago and lumbar radiculopathy. Treatments have included rest and activity modification. In the Initial Comprehensive Primary Treating Physician Report dated 1/28/15, the injured worker complains of dull, achy mid back pain and muscle spasms. She rates her pain level a 7-8/10. She describes the pain as constant and moderate to severe. She complains of sharp, burning, radicular low back pain and muscle spasms. She describes this pain as constant and severe. She has pain associated with numbness and tingling in both legs. On physical examination, she has tenderness to palpation of thoracic spinous processes with muscle guarding. She has decreased range of motion in her thoracic area. She has a positive Kemp's test. She has tenderness to palpation of lumbar spinous processes with paraspinal muscle guarding. She has some decreased range of motion in lumbar spine. She has positive straight leg raises with both legs. The treatment plan includes prescriptions for medications, for shockwave therapy, for courses of physical therapy and acupuncture and for Terocin patches.

IMR ISSUES, DECISIONS AND RATIONALES

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

Terocin patches #6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), topical lidocaine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics. Decision based on Non-MTUS Citation Treatment Guidelines from the Medical Letter, April 1, 2013, Issue 128: Drugs for Pain Interventions and Guidelines.

Decision rationale: Terocin is a topical multidrug compound, which contains methylsalicylate, Lidocaine, capsaicin, and menthol. Topical analgesics are recommended for neuropathic pain when anticonvulsants and antidepressants have failed. Compounded topical analgesics are commonly prescribed and there is little to no research to support the use of these compounds. Furthermore, the guidelines state that "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Methylsalicylate is a topical salicylate and is recommended, being significantly better than placebo in chronic pain. Lidocaine is recommended for localized peripheral pain after the evidence of a trial for first-line therapy. It is only FDA approved for the treatment of post-herpetic neuralgia. The guidelines state that further research is needed to recommend this treatment for chronic neuropathic pain. Capsaicin is recommended only as an option in patients who have not responded or cannot tolerate other treatments. It is recommended for osteoarthritis, fibromyalgia, and chronic non-specific back pain and is considered experimental in high doses. Topical analgesics containing menthol, methylsalicylate or capsaicin are generally well tolerated, but there have been rare reports of severe skin burns requiring treatment or hospitalization. This medication contains drugs that are not recommended. Therefore, the medication cannot be recommended. The request is not medically necessary.

Dicopanor 5 mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), topical.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Medical Letter on Drugs and Therapeutics; March 8, 2010 (Issue 1333) Treatment Guidelines from the Medical Letter, Issue 129, May 1, 2013: Drugs for Allergic Disorders.

Decision rationale: Dicopanor is the first generation H1-antihistamine, diphenhydramine. Antihistamines are used for relief of the itching, sneezing and rhinorrhea that characterize mild to moderate allergic rhinitis. First-generation H1-antihistamines such as diphenhydramine can cause impairment of CNS function with or without sedation. They can interfere with learning and memory, impair performance on school examinations, decrease work productivity, and increase the risk of on-the-job injuries. Impairment is particularly evident during performance of

multiple concurrent tasks or of complex sensorimotor tasks such as driving, and can occur before drowsiness or sedation. When these medications are taken at night, adverse effects on wakefulness and psychomotor performance can persist the next day. With regular use, tolerance to both sedation and performance impairment can develop. First-generation H1-antihistamines can also cause anticholinergic effects such as dry mouth and urinary retention. In this case, the patient has been taking the medication since January 2015 for its sedative effects. There is no documentation to support the diagnosis of insomnia; In addition, there is no documentation that the patient has symptoms of itching, sneezing, or rhinorrhea. Medical necessity is not established and there is a high risk of adverse effects. The request should not be authorized.

Urinalysis periodically: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, urine drug testing.

Decision rationale: Chronic Pain Medical Treatment Guidelines state that urinary drug testing should be used if there are issues of abuse, addiction, or pain control in patients being treated with opioids. ODG criteria for Urinary Drug testing are recommended for patients with chronic opioid use. Patients at low risk for addiction/aberrant behavior should be tested within 6 months of initiation of therapy and yearly thereafter. Those patients with moderate risk for addiction/aberrant behavior should undergo testing 2-3 times/year. Patients with high risk of addiction/aberrant behavior should be tested as often as once per month. In this case, there is no documentation of the date or results of last urine drug test or that the patient has any addiction/aberrant behavior. The lack of documentation does not allow determination of necessity. The request should not be medically necessary.

Outpatient physical therapy 3 times a week for 6 weeks to the thoracic/lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: Chronic Pain Medical Treatment Guidelines state that there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, TENS units, ultrasound, laser treatment, or biofeedback. They can provide short-term relief during the early phases of treatment. Active treatment is associated with better outcomes and can be managed as a home exercise program with supervision. ODG states that physical therapy is more effective in short-term follow up. Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing

with the physical therapy). When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. Recommended number of visits for myalgia and myositis is 9-10 visits over 8 weeks; and for neuralgia, neuritis, and radiculitis is 8-10 visits over 4 weeks. In this case, physical therapy was ordered January 23, 2015. There is no documentation of objective evidence of functional improvement. In addition the requested number of 18 visits surpasses the number of six recommended for clinical trial to determine functional improvement and maximum number of 10 visits recommended for treatment. The request is not medically necessary.

Acupuncture 3 times a week for 6 weeks to the thoracic/lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: Section 9792.24.1 of the California Code of regulations states that Acupuncture is used as an option when pain medication is reduced or not tolerated or as an adjunct to physical rehabilitation. It is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. Acupuncture with electrical stimulation is the use of electrical current on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites. Specific indications for treatment of pain include treatment of joint pain, joint stiffness, soft tissue pain and inflammation, paresthesias, post-surgical pain relief, muscle spasm and scar tissue pain. OGD states that acupuncture is not recommended for acute back pain, but is recommended as an option for chronic low back pain in conjunction with other active interventions. Acupuncture is recommended when use as an adjunct to active rehabilitation. Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows: 1) Time to produce functional improvement: 3 to 6 treatments. 2) Frequency: 1 to 3 times per week. 3) Optimum duration: 1 to 2 months. Acupuncture treatments may be extended if functional improvement is documented. In this case, acupuncture was ordered January 23, 2015. There is no documentation of objective evidence of functional improvement. In addition, the requested number of 18 visits surpasses the number of three to six recommended for clinical trial to produce functional improvement. The request is not medically necessary.

Deprizine 5mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Medical Letter on Drugs and Therapeutics; March 8, 2010 (Issue 1333) p. 17: Primary Prevention of Ulcers in Patients Taking Aspirin or NSAIDs Treatment Guidelines from the Medical Letter, Issue 129.

Decision rationale: Deprizine is the H2-blocker antagonist, ranitidine. It is indicated for the treatment of peptic ulcer disease and been shown to prevent NSAID-related gastric ulcers in high doses. In this case, the patient did not have diagnosis of ulcer disease. The patient did not have any complaint of nausea or dyspepsia. Medical necessity has not been established. The request should not be authorized.

Fanatrex 25mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: Fanatrex is the anti-epileptic medication gabapentin. Gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia, has been considered as a first-line treatment for neuropathic pain, and has FDA approval for treatment of post-herpetic neuralgia. Gabapentin appears to be effective in reducing abnormal hypersensitivity, to have anti-anxiety effects, and may be beneficial as a sleep aid. Gabapentin has a favorable side-effect profile, few clinically significant drug-drug interactions and is generally well tolerated; however, common side effects include dizziness, somnolence, confusion, ataxia, peripheral edema, dry mouth, and weight gain. It has been recommended for the treatment of pain from spinal cord injury, fibromyalgia, lumbar spinal stenosis, and chronic regional pain syndrome. Recommended trial period is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. If inadequate control of pain is found, a switch to another first-line drug is recommended. In this case, the patient has been taking the medication since at least January 2015 and has not obtained analgesia. Switch to another first-line drug is recommended. The request should not be authorized.

Synapryn 10mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: Synapryn is the medication tramadol. Tramadol is a synthetic opioid affecting the central nervous system. It has several side effects, which include increasing the risk of seizure in patients taking SSRI's, TCA's and other opioids. Chronic Pain Medical Treatment

Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain of function. It is recommended for short-term use if first-line options, such as acetaminophen or NSAIDS have failed. In this case, the patient has been receiving tramadol since at least January 2015 and has not obtained analgesia. In addition, there is no documentation that the patient has signed an opioid contract or is participating in urine drug testing. Criteria for long-term opioid use have not been met. The request should not be authorized.

Tabradol 1mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril).

Decision rationale: Tabradol is the muscle relaxant cyclobenzaprine. Cyclobenzaprine is recommended as an option, for a short course of therapy. It has been found to be more effective than placebo with greater adverse side effects. Its greatest effect is in the first 4 days. Treatment should be brief. Non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment (less than two weeks) of acute exacerbations in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also, there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. In this case, the patient has been receiving cyclobenzaprine since at least January 2015. The duration of treatment surpasses the recommended short-term duration of two weeks. The request is not medically necessary.