

Case Number:	CM15-0122168		
Date Assigned:	07/24/2015	Date of Injury:	06/21/2010
Decision Date:	09/18/2015	UR Denial Date:	05/27/2015
Priority:	Standard	Application Received:	06/24/2015

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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational 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 sustained a work related injury on 6/21/10. The diagnoses have included cervical spine strain/sprain rule out disc displacement, cervical radiculopathy, bilateral shoulder strain/sprain, derangement, left wrist strain/sprain rule out derangement, left wrist tenosynovitis, abdominal discomfort and pain, thoracic strain/sprain rule out disc displacement, status post lumbar spine surgery, lumbar radiculopathy, urine and fecal incontinence, anxiety disorder, mood disorder and sleep disorder. Treatments have included lumbar epidural steroid injections, oral medications, medicated pain creams/gels, medicated pain patches, lumbar spine surgery, physical therapy, and acupuncture and shockwave therapy. In the PR-2 dated 3/2/15, the injured worker complains of burning, constant, moderate to severe, radicular neck pain and muscles spasms. She has pain that radiates to both arms and associated numbness and tingling. She rates this pain level a 7-8/10. She complains of burning, constant and moderate to severe bilateral shoulder pain that radiates down her arms to the fingers with associated muscle spasms. She rates this pain level a 5-6/10. She complains of intermittent to frequent, mild to moderate, burning left wrist pain. She rates this pain level a 3/10. She complains of intermittent to frequent, mild to moderate burning mid back pain and muscle spasms. She rates this pain level a 3/10. She complains of constant, moderate to severe, burning low back pain with spasms. She has associated numbness and tingling in both legs. She rates this pain a 7-8/10. She is experiencing bowel and bladder incontinence. She also complains of abdominal pain and discomfort. On physical examination, she has tenderness to palpation at the suboccipital region, trapezius and scalene muscles. She has decreased range of motion in neck.

She has tenderness to palpation at the deltopectoral groove and at the insertion of the supraspinatus muscle. She has mildly decreased range of motion in both shoulders. She has tenderness to palpation over the carpal bones and over the thenar and hypothenar eminence in the left wrist. She has mildly decreased range of motion in the left wrist. She has palpable tenderness noted over bilateral thoracic paraspinals. She has pain with toe walking. She is able to squat to approximately 40% of normal due to pain in low back. She has palpable tenderness at the lumbar paraspinal muscles and over the lumbosacral junction. She has positive straight leg raises with both legs. She has decreased range of motion in low back. She is frustrated by her injury and is experiencing stress, anxiety, insomnia and depression brought on by her chronic pain, physical limitations, inability to work and uncertain future since her injury. She is not working. The treatment plan includes refills of medications and to continue with course of shockwave therapy for more sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Terocin patches: Upheld

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

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

Decision rationale: Per CA MTUS guidelines, Terocin is a compounded topical analgesic agent consisting of capsaicin, menthol, and methyl salicylate. Although recommended as an option, topical analgesics are used primarily for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Furthermore, they are largely experimental. "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." "Capsaicin: recommended only as an option in patients who have not responded or are intolerant to other treatments." "There are positive randomized studies with capsaicin cream in patients with osteoarthritis, fibromyalgia, and chronic nonspecific back pain, but it should be considered experimental in very high doses. Although topical capsaicin has moderate to poor efficacy, it may be particularly useful (alone or in conjunction with other modalities) in patients whose pain has not been controlled successfully with conventional therapy." There is no information noted on the use of menthol or methyl salicylate in a topical preparation. She has been using medicated patches for an indeterminate amount of time. There is no documentation on how often she is using the patches, what body part she is applying it to or how much pain relief she obtains from its use. Since there are components of this patch without information and for other reasons listed above, the requested treatment of Terocin patches consisting of Capsaicin, Menthol and Methyl salicylate is not medically necessary.

Deprizine 15mg/ml 250ml: 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 - Gastrointestinal Symptoms and Cardiovascular Risks Page(s): 69.

Decision rationale: Per CA MTUS guidelines, Deprizine is ranitidine in an oral suspension. Ranitidine is prescribed without any rationale provided. If ranitidine is prescribed as co-therapy 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. Co-therapy 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.

Dicopanol 5mg/ml 150ml: 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) 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.

Fanatrex 25mg/ml 420ml: 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: Per CA MTUS guidelines, 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 are no physician reports, which adequately address the specific symptomatic and functional benefit from the anti-epilepsy drugs (AEDs) used to date. Note the criteria for a "good" response per the MTUS. AED's have a significant risk of teratogenicity and alterations in

contraceptives and this must be discussed with the patient. There is no evidence that this reproductive-age woman has been counseled regarding this significant issue. Gabapentin is not medically necessary based on the lack of any clear indication, the lack of counseling and consent regarding the reproductive risks, and the lack of significant symptomatic and functional benefit from its use to date. This request is not medically necessary.

Synapryn 10gm/1ml 500ml: 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 Glucosamine, Opioids Page(s): 50, 77-80.

Decision rationale: Synapryn (Tramadol with glucosamine) 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 OA, 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. 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 which 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/ml 250ml: 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 Cyclobenzaprine, Muscle Relaxants Page(s): 42, 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 pain with no evidence of prescribing for flare-ups, and the pain is in the extremity and 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 and 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.

Cyclobenzaprine gel, 5% cream 10gms: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, Topical Analgesics Page(s): 42, 111-113.

Decision rationale: Per CA MTUS guidelines, although recommended as an option, topical analgesics are used primarily for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Furthermore, they are largely experimental. "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." There is no evidence for use of any muscle relaxant as a topical product. Since there is no documented evidence that muscle relaxants work in a topical preparation, the requested treatment of Cyclobenzaprine gel is not medically necessary.

Ketoprofen 20% cream 167gm: 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): 111-113.

Decision rationale: Per CA MTUS guidelines, although recommended as an option, topical analgesics are used primarily for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Furthermore, they are largely experimental. "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Ketoprofen is an agent that is not currently FDA approved for a topical application. It has an extremely high incidence of photo contact dermatitis. Since it is not recommended for use in a topical preparation, the requested treatment of Ketoprofen cream is not medically necessary.

Shockwave therapy for the bilateral shoulders and left wrist/hand x 18 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Extracorporeal shockwave therapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Extracorporeal Shockwave Therapy.

Decision rationale: Per ODG, Extracorporeal Shockwave Therapy (ESWT) is recommended in the treatment of burn wounds. "Shock wave therapy may work by increasing blood flow to the tissues and providing an anti-inflammatory effect." Recommended for calcifying tendinitis but not for other shoulder disorders. Because the injured worker does not have calcifying tendinitis and it is not recommended for any other joints, the requested treatment of shockwave sessions is not medically necessary.