

<b>Case Number:</b>	CM15-0037537		
<b>Date Assigned:</b>	04/09/2015	<b>Date of Injury:</b>	09/26/2012
<b>Decision Date:</b>	06/16/2015	<b>UR Denial Date:</b>	01/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/27/2015

### 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 41-year-old female who has reported widespread pain after a pushing injury in 2011 and a fall on 09/26/2012. The recent diagnoses include cervical spine sprain/strain, rule-out herniated nucleus pulposus, cervical radiculopathy, left shoulder sprain/strain r/o rotator cuff tear, lumbar spine sprain/strain r/o herniated nucleus pulposus, lumbago, lumbar radiculopathy, left knee sprain/strain r/o meniscus tear, left ankle sprain/strain r/o internal derangement, anxiety disorder, stress and sleep disorder. The medical records prior to the evaluation on 11/26/14 show a left shoulder MRI on 3/4/11, a lumbar MRI on 3/4/11, courses of physical therapy, chiropractic care, acupuncture, naproxen, Norco, a shoulder injection, electro diagnostic testing on 5/2/13, and a lumbar MRI on 2/20/13. There was no specific functional improvement from acupuncture. Treatment to date has included medications, physical therapy, steroid injection, lumbar support belt, acupuncture and a cane. Prior records do not show ongoing neck and upper extremity symptoms. The current primary treating physician first evaluated this injured worker on 11/26/14. According to the report of that evaluation, prior medical care had included x-rays, an MRI, courses of physical therapy, an injection, a lumbar brace, acupuncture, and medications. There was no discussion of the specific results of any of this care. There was ongoing neck and low back pain with extremity symptoms, shoulder pain, knee pain ankle pain, anxiety, stress, and depression. No medications were listed. The symptomatic areas were painful with limited range of motion, impingement signs at the shoulder, there were positive provocative signs at the knee, and ankle laxity. There were C6-7 sensory deficits in the left upper extremity, and left L5-S1 sensory deficits in the lower extremity. The treatment plan included the oral suspensions, cream, radiographs, TENS, hot/cold

unit, physical therapy, acupuncture, ECSWT, FCE, psychologist referral, a sleep study, MRIs, electro diagnostic testing, LINT, Terocin, and a temporarily totally disabled work status. Patient-specific indications for the treatment plan were not sufficiently explained, and nearly all of the requested items had no specific rationale or indications discussed. There was no discussion of the need for further testing and treatment in light of what had already been completed. On 1/29/15 Utilization Review non-certified the 25 tests and treatments now referred for Independent Medical Review. Radiographs of multiple body parts were certified. The MTUS, the Official Disability Guidelines, and medical literature were cited. Note was made of prior electro diagnostic testing and a lumbar MRI in 2013.

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

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

#### **EMG/NCV of the bilateral upper extremities: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints Page(s): 182, 168-171, 213, 196-201.

**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. This injured worker has had prior electro diagnostic testing that was not discussed by the treating physician. 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. 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.

#### **EMG/NCV of the bilateral lower extremities: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303 and 309.

**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. This injured worker has had prior electro diagnostic testing and imaging that was not discussed by the treating physician. The treating physician did not adequately address the content of prior testing, treatment, or medical records. Based on the current clinical information, electro diagnostic testing is not medically necessary, as the treating physician has not provided the specific indications, clinical examination, and sufficient review of prior treatment as outlined in the MTUS.

**Physical therapy 3 x 8 for the cervical spine, left shoulder, lumbar spine, left knee, and ankle:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 6 Pain, Suffering and the Restoration of Function, page 114.

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

**Decision rationale:** The treating physician has not provided an adequate prescription, which must contain diagnosis, duration, frequency, and treatment modalities, at minimum. Per the MTUS, Chronic Pain section, functional improvement is the goal rather than the elimination of pain. The maximum recommended quantity of physical Therapy 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 therapy, which 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 therapy 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.

**Sleep Study: Upheld**

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

**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, Polysomnography and Other Medical Treatment Guidelines Other Medical Treatment Guideline or Medical Evidence: Practice Parameters for the Indications for Polysomnography and Related Procedures: An Update for 2005. SLEEP 2005;28(4):499-521.

**Decision rationale:** The MTUS does not provide direction for evaluating or treating sleep disorders. The American Academy of Sleep Medicine (AASM) has published practice parameters for polysomnography (PSG) and related procedures. The conditions addressed included sleep related breathing disorders, other respiratory disorders, narcolepsy, parasomnias and sleep related seizure disorders, restless legs syndrome and periodic limb movement sleep disorder, depression with insomnia, and circadian rhythm sleep disorders. The initial evaluation should include a thorough sleep history and a physical examination that includes the respiratory, cardiovascular, and neurologic systems. The general evaluation should serve to establish a differential diagnosis of SRBDs, which can then be used to select the appropriate test(s). The general evaluation should therefore take place before any PSG is performed. The Official Disability Guidelines recommend polysomnography under some circumstances, including, "Excessive daytime somnolence; Sleep-related breathing disorder or periodic limb movement disorder is suspected; & Insomnia complaint for at least six months (at least four nights of the week), unresponsive to behavior intervention and sedative/sleep-promoting medications and psychiatric etiology has been excluded. A sleep study for the sole complaint of snoring, without one of the above mentioned symptoms, is not recommended."The treating physician has not provided sufficient indications for this study in light of the published guidelines and medical evidence. There is no evidence of a thorough medical evaluation that establishes the presence of all relevant medical conditions. The recommended prior conservative care prior to ordering a sleep study, per the Official Disability Guidelines, has not been completed. A sleep study is not medically necessary based on lack of sufficient medical evaluation and the lack of sufficient current indications.

**Deprizine 5mg/ml #250ml: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Library of Medicine.

**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.

**Dicopanal 5mg/ml #150ml:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [www.drugs.com](http://www.drugs.com).

**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 Dicopanal 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. Dicopanal is not medically necessary on this basis alone. In addition, Dicopanal 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. Dicopanal 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:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18-19.

**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. 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 and the lack of counseling and consent regarding the reproductive risks.

**Synapryn 10mg/ml #500ml: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [www.dailymed.nlm.nih.gov](http://www.dailymed.nlm.nih.gov).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Glucosamine (and Chondroitin Sulfate) Page(s): 77-80 and 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. And 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:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants.

**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 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 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.

**Cyclobenzaprine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medications Page(s): 11-113.

**Decision rationale:** This formulation appears to be topical. 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. This topical agent is not medically necessary.

**Terocin patches:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain, Topical Analgesics Page(s): 60 and 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.

**Ketoprofen cream:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112-113.

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

**Decision rationale:** Note that topical Ketoprofen is not FDA approved. This treatment is not recommended per the MTUS citation above. Given the lack of supporting guidelines or medical indications, this topical agent is not medically necessary.

**Acupuncture 3 x 6 for the cervical spine, left shoulder, lumbar spine, left knee, and ankle:** Upheld

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

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

**Decision rationale:** The prescription for acupuncture is evaluated in light of the MTUS recommendations for acupuncture. 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. An initial course of acupuncture is 3-6 visits per the MTUS. The records refer to 18 visits, which exceeds the quantity recommended in the MTUS. The treating physician did not address the results of the prior course of acupuncture, for which there was no apparent functional improvement. Per the MTUS, functional improvement is required for any additional acupuncture treatment. An additional course of acupuncture is not medically necessary based on a prescription which exceeds the quantity recommended in the MTUS, lack of benefit from prior acupuncture, and lack of specific indications per the MTUS.

**Shockwave therapy for the cervical and lumbar spine, up to 6 treatments:** 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) Low Back chapter, Extracorporeal shock wave therapy (ESWT).

**Decision rationale:** The Official Disability Guidelines states that shockwave therapy for the low back is not recommended due the lack of evidence. The MTUS does not address shockwave therapy for the spine. The Official Disability Guidelines do not address shockwave therapy for the neck but the low back component is not recommended. As a result, shockwave therapy is not medically necessary.

**Shockwave therapy for the left shoulder, left knee, and ankle, up to 3 treatments:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 14 Ankle and Foot Complaints Page(s): 203, 371 and 376. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee chapter, Shoulder chapter, Ankle and Foot chapter, Extracorporeal shock wave therapy (ESWT).

**Decision rationale:** The Official Disability Guidelines states that shockwave therapy for the knee is "under study" for patellar tendinopathy and long-bone hypertrophic nonunions. Neither of these conditions is present in this injured worker. Shockwave therapy for the knee is not addressed in the MTUS. Per the cited guideline, shockwave therapy for the knee is not medically necessary. The MTUS cited above, states that ECSWT is an option for calcifying tendinitis. This condition is not present in this injured worker. The Official Disability Guidelines recommend ESWT for the shoulder if there is calcifying tendinitis after 6 months of standard treatment and also list several treatment criteria and contraindications. The treating physician has not provided any information in compliance with this guideline and the injured worker does not meet these Official Disability Guidelines recommendations. The ECSWT is not medically necessary as a result. The MTUS states that ESWT is an option for plantar fasciitis. The Official Disability Guidelines recommend it only for plantar fasciitis, and only the low energy form. This injured worker does not meet the criteria in the guidelines. ESWT is therefore not medically necessary.