

Case Number:	CM13-0030945		
Date Assigned:	12/04/2013	Date of Injury:	11/29/2011
Decision Date:	01/30/2014	UR Denial Date:	09/09/2013
Priority:	Standard	Application Received:	10/02/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and Hand Surgery and is licensed to practice in Texas. 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 physician 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/services.

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 patient is a 54-year-old male who reported an injury on November 29, 2011 due to cumulative trauma. It was noted that patient reportedly gradually developed pain at the neck associated with numbness and weakness in the arms. The patient underwent electrodiagnostic studies that supported chronic C7 nerve root irritation, and evidence of bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome. The patient also underwent an MRI of the left shoulder that revealed minimal subacromial bursitis, osteoarthropathy of the acromioclavicular joint and minimal glenohumeral joint effusion. The patient's most recent clinical examination findings of the left shoulder revealed sharp shoulder pain radiating into the hand rated at a 7/10 to 8/10 exacerbated by movement. The patient also complained of left elbow and left wrist pain. The patient had a positive cervical distraction test and a positive cervical compression test with limited cervical range of motion described as 30 degrees in flexion, 30 degrees in extension, 60 degrees in left rotation, 50 degrees in right rotation, and 25 degrees in right and left lateral flexion. Physical findings of the left shoulder included limited range of motion described as 125 degrees in flexion, 30 degrees in extension, 130 degrees in abduction, 70 degrees in adduction, 75 degrees in external rotation, and 60 degrees in internal rotation with a positive impingement sign and empty can test. Physical findings of the left elbow revealed tenderness to palpation along the lateral epicondyles with a positive Cozen sign. Physical findings of the left wrist included a positive Tinel's sign. The patient's diagnoses included cervical spine disc herniation, cervical radiculopathy, left shoulder impingement syndrome, left elbow pain, and left wrist internal derangement. The patient's treatment plan included continued medication usage, consultation with an orthopedic surgeon regarding the left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orthopedic Consultation regarding left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 127.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

Decision rationale: The clinical documentation submitted for review does provide evidence that the patient has limited range of motion and left shoulder pain complaints. However, the ACOEM Practice Guidelines recommend surgical consultation when there are red flag conditions, activity limitations in combination with the existence of a surgical lesion, failure to increase range of motion and strength with conservative measures and the existence of a surgical lesion, and clear clinical and imaging evidence of a lesion that would benefit from surgical repair. The clinical documentation submitted for review does not provide evidence that the patient's deficits have not been sufficiently resolved with conservative treatments. Additionally, the imaging study does not provide a clearly identified lesion that would benefit from surgical intervention. The clinical documentation submitted for review does not provide any evidence of significant activity limitations that would benefit from surgical intervention. As such the requested orthopedic consultation regarding the left shoulder is not medically necessary or appropriate.

Deprizine: 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 and <http://www.drugs.com/pro/Deprizine.html>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation online source: MedlinePlus

Decision rationale: has continued pain complaints. However, an online resource, [REDACTED], does indicate that Deprizine is primarily used as a gastrointestinal protectant. The clinical documentation submitted for review does not provide any evidence that the patient is at significant gastrointestinal risk or currently experiencing gastrointestinal upset related to the medication usage. Therefore, the continued use of this medication would not be indicated. Additionally, all medications used in the treatment of chronic pain should be supported by functional benefit and symptom relief. The clinical documentation submitted for review does not provide any functional benefit or symptom relief related to the medication. As such, the requested Deprizine is not medically necessary or appropriate.

Dicoprofen: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.drugs.com/pro/Dicoprofen.html

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation online source: MedlinePlus

Decision rationale: The clinical documentation submitted for review does provide evidence that the patient has continued pain complaints. However, an online resource, [REDACTED], also indicates that Dicopanol is used to relieve hay fever, allergy, and common cold symptoms. The clinical documentation submitted for review does not provide any evidence that the patient has any symptoms related to hay fever, allergies, or the common cold that would require this type of medication. Therefore, continued use would not be indicated. Additionally, all medications used in the treatment of chronic pain should be supported by functional benefit and symptom relief. The clinical documentation submitted for review does not provide any functional benefit or symptom relief related to the medication. As such, the requested Dicopanol is not medically necessary or appropriate.

Synapryn: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81. Decision based on Non-MTUS Citation ODG, Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-going Management Sections Page(s): 78. Decision based on Non-MTUS Citation online source: DailyMed.

Decision rationale: The clinical documentation submitted for review does provide evidence that the patient has continued pain complaints. However, an online resource, [REDACTED], states that Synapryn is a compounded medication that contains tramadol and hydrochloride and glucosamine. The California MTUS recommends that medications used in the management of chronic pain be introduced to a patient serially. Therefore, a compounded medication would not be supported. Additionally, all medications used in the treatment of chronic pain should be supported by functional benefit and symptom relief. The clinical documentation submitted for review does not provide any functional benefit or symptom relief related to the medication. As such Synapryn is not medically necessary or appropriate.

Tabradol: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63. Decision based on Non-MTUS Citation ODG, Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain Section Page(s): 60. Decision based on Non-MTUS Citation online source: RXList.

Decision rationale: The clinical documentation submitted for review does provide evidence that the patient has continued pain complaints. However, an online resource, [REDACTED], indicates that Tabradol is a compounded medication with cyclobenzaprine and MAOI inhibitors. The California MTUS recommends that medications be introduced singularly when being used to

manage a patient's chronic pain. Therefore, compounded agents would not be recommended. Additionally, all medications used in the treatment of chronic pain should be supported by functional benefit and symptom relief. The clinical documentation submitted for review does not provide any functional benefit or symptom relief related to the medication. As such, the requested Tabradol is not medically necessary or appropriate.

Cyclophene: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112-113. Decision based on Non-MTUS Citation ODG, Topical Analgesics

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section Page(s): 111. Decision based on Non-MTUS Citation online source: WebMD.

Decision rationale: The clinical documentation submitted for review does provide evidence that the patient has continued pain complaints. However, an online resource, [REDACTED], documents that cyclophene is a topical agent that contains cyclobenzaprine. The California MTUS does not recommend cyclobenzaprine as a topical agent due to lack of scientific evidence to support efficacy and safety. Additionally, all medications used in the treatment of chronic pain should be supported by functional benefit and symptom relief. The clinical documentation submitted for review does not provide any functional benefit or symptom relief related to the medication. As such, the requested Cyclophene is not medically necessary or appropriate.

Ketoprofen cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112-113. Decision based on Non-MTUS Citation ODG, Topical Analgesics

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

Decision rationale: The clinical documentation submitted for review does provide evidence that the patient has continued pain complaints. However, the California MTUS does not support the use of Ketoprofen cream as it is not FDA approved as a topical agent. Additionally, all medications used in the treatment of chronic pain should be supported by functional benefit and symptom relief. The clinical documentation submitted for review does not provide any functional benefit or symptom relief related to the medication. As such, the requested Ketoprofen cream is not medically necessary or appropriate.