

Case Number:	CM13-0057655		
Date Assigned:	12/30/2013	Date of Injury:	07/08/2010
Decision Date:	04/03/2014	UR Denial Date:	11/19/2013
Priority:	Standard	Application Received:	11/25/2013

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 Family Practice, 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. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 59-year-old who reported an injury on 07/08/2010. The patient was reportedly injured when he was struck in the back of the head with a piece of equipment. The patient was diagnosed with head trauma, neck pain, history of subdural hematoma, tinnitus, disturbance of vision, dizziness, hearing loss, anxiety disorder, stress, and mood disorder. The patient was seen by [REDACTED] on 11/25/2013. The patient reported persistent pain to the head and neck. Physical examination revealed tenderness to palpation, intact sensation, and 5/5 motor strength. Treatment recommendations included continuation of current medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

One prescription of Cyclophene 120 gm: 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 Page(s): 111-113.

Decision rationale: The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primary recommended for

neuropathic pain when trials of antidepressants and anticonvulsants have failed. As per the documentation submitted, the patient's physical examination did not reveal any evidence of neuropathic pain. There is also no documentation of a failure to respond to first line oral medication. Despite ongoing use of this medication, the patient continues to report persistent pain. The request for one prescription of Cyclophene 120 gm is not medically necessary or appropriate.

One prescription for the compound of Ketoprofen 120 gm: Upheld

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

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

Decision rationale: The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines state 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. As per the documentation submitted, the patient's physical examination did not reveal any evidence of neuropathic pain. There is also no documentation of a failure to respond to first line oral medication. Despite ongoing use of this medication, the patient continues to report persistent pain. The request for one prescription for the compound of Ketoprofen 120 gm is not medically necessary or appropriate.

One prescription of Tabradol 1 mg/ml, 250 ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines state muscle relaxants are recommended as non-sedating second line options for short term treatment of acute exacerbations in patients with chronic low back pain. Cyclobenzaprine should not be used for longer than two to three weeks. The patient has continuously utilized this medication. There is no evidence of palpable muscle spasm or spasticity upon physical examination. There is also no indication that this patient cannot safely swallow pills or capsules. The request for one prescription of Tabradol 1 mg/ml, 250 ml, is not medically necessary or appropriate.

One prescription of Deprizine 15 mg/ml, 250ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. There is no indication of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the patient does not meet criteria for the requested medication. Additionally, there is no indication that this patient cannot safely swallow pills or capsules. The request for one prescription of Deprizine 15 mg/ml, 250ml, is not medically necessary or appropriate.

One prescription of Dicopanol 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, Neck and Upper Back Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation the Official Disability Guidelines (ODG), Chronic Pain Chapter, Insomnia Treatment Section

Decision rationale: The Physician Reviewer's decision rationale: Official Disability Guidelines state diphenhydramine is a sedating antihistamine, often utilized as an over-the-counter medication for insomnia treatment. The patient has continuously utilized this medication. However, there is no indication of chronic insomnia or a chronic condition where an antihistamine is necessary. There is also no indication that this patient cannot safely swallow pills or capsules. The request for one prescription of Dicopanol 150 ml is not medically necessary or appropriate.