

Case Number:	CM14-0015094		
Date Assigned:	02/28/2014	Date of Injury:	03/02/2012
Decision Date:	07/29/2014	UR Denial Date:	01/30/2014
Priority:	Standard	Application Received:	02/06/2014

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. The expert reviewer is Board Certified in 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 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/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 injured worker is a 54-year-old female who reported an injury on 03/02/2012, the mechanism of injury was not provided. The clinical note dated 01/09/2014 noted the injured worker presented with bilateral hand and wrist pain and sharp pain in the lateral aspect of the first digit on the right hand. She reported constant pain and weakness causing her to drop things that she is holding. Upon exam, there was tenderness of the bilateral wrists with weakness, and a 6/10 pain level. The diagnoses were pain in joint and hand, pain in forearm, and carpal tunnel syndrome. Prior treatment included discussion of a Functional Capacity Evaluation, Tramadol, and ice to alleviate her symptoms. The provider recommended Dyotin 250 mg, "Flurbitac" 100 mg, TheraFlex transdermal cream 180 mg, Keratek gel 4 oz, "Vicosetron" 10/300/2 mg, and Cyclobenzaprine 7.5 mg. The provider's rationale was not provided. The request for authorization form was dated 01/22/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

DYOTIN SR 250 MG QUANTITY 60: 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 Specific Antiepilepsy Drugs Page(s): 18.

Decision rationale: The California MTUS Guidelines note that relief with the use of this medication is generally temporary. The measures of the lasting benefit from this modality should include evaluating effective pain relief and relationship to improvements in function and increased activity. The guidelines note effectiveness for treatment of diabetic painful neuropathy and postherpetic neuralgia and it has been considered a first line treatment for neuropathic pain. The medical documents lack evidence of a diagnosis or symptoms that would be congruent with the guidelines recommendations. There is a lack of a complete and adequate pain assessment for the injured worker. In addition, the request does not include the frequency of the proposed medication. As such, the request for Dyotin sr 250 mg, quantity 60 is not medically necessary and appropriate.

FLURBITAC 100/100 MG QUANTITY 60: 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, specific drug list and adverse effects Page(s): 70.

Decision rationale: The California MTUS Guidelines state that all NSAIDs are associated with risk of cardiovascular events, including MI, stroke, and onset or worsening of pre-existing hypertension. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual treatment goals. There is lack of evidence in the medical records provided of a complete and accurate pain assessment of the injured worker, and the efficacy of the medication. In addition, the request does not include the frequency of the proposed medication. As such, the request for Flurbitac 100/100 mg # 60 is not medically necessary and appropriate.

THERAFLEX TRANSDERMAL CREAM 180 MG, 120 GMQUANTITY 1: 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 Topical Analgesics Page(s): 111.

Decision rationale: The California MTUS states that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesia is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended is not recommended. The MTUS guidelines note that Lidoderm is the only FDA approved topical formulation of Lidocaine. The guidelines note Lidocaine is not recommended. The included medical documents lack evidence of a trial of antidepressants and anticonvulsants have failed. The provider's request for TheraFlex transdermal cream does not indicate the site that the transdermal cream is intended for. In addition, the request does not

include the frequency of the proposed medication. Therefore, the request for Theraflex transdermal cream 180 mg, 120 mg, quantity 1 is not medically necessary and appropriate.

KERATEK GEL 4 OUNCE QUANTITY 1: 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 Topical Analgesics Page(s): 111.

Decision rationale: The California MTUS Guidelines state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesia is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Topical salicylate is significantly better than placebo in chronic pain. In this case, the provider's request does not indicate the frequency or the site that the Keratek gel is intended for. As such, the request for Keratek gel 4 ounces quantity 1 is not medically necessary and appropriate.

VICOSETRON 10/300/2MG QUANTITY 60: 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 Opioids, Criteria for use Page(s): 78.

Decision rationale: The California MTUS recommends the use of opioids for ongoing management of chronic low back pain. MTUS guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is lack of documentation evidence of an objective assessment of the injured worker's pain level, functional status, evaluation of risk for aberrant drug abuse behavior, and side effects. In addition, the request does not include the frequency of the proposed medication. As such, the request for Vicosetron 10/300/2 mg quantity 60 is not medically necessary and appropriate.

CYCLOBENZAPRINE 7.5 MG QUANTITY 40: 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 (Flexeril) Page(s): 41.

Decision rationale: The California MTUS Guidelines recommend Cyclobenzaprine as an option for a short course of therapy. The greatest effect of this medication is in the first 4 days of

treatment, suggesting that shorter courses may be better. Treatment should be brief. The request for Cyclobenzaprine 7.5 mg with a quantity of 40 exceeds the guideline recommendation of short-term therapy. The provided medical records lack documentation of significant objective functional improvement with the medication. The provider's rationale for the request was not provided within the documentation. In addition, the request does not include the frequency of the proposed medication. Therefore, the request for Cyclobenzaprine 7.5 mg is not medically necessary and appropriate.