

Case Number:	CM14-0122418		
Date Assigned:	08/06/2014	Date of Injury:	07/31/2013
Decision Date:	09/12/2014	UR Denial Date:	07/21/2014
Priority:	Standard	Application Received:	08/04/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Texas and Ohio. 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 63-year-old male who reported an injury on 07/31/2013. Reportedly, he was in the process of painting a wall in a squatting position; as he stood up, he hit his head on a windowsill planter. The injured worker sustained injuries on 10/18/2013 reportedly as he was in the process of a ladder when it suddenly fell; he injured his left hand, left shoulder, elbow, wrist, hand, and fingers. The injured worker's treatment history included medications, x-rays, physical therapy, and EMG/NCV studies. The injured worker was evaluated on 06/24/2014. It was documented the injured worker complained of throbbing headaches, left shoulder pain, left elbow pain and muscle spasms, left wrist pain and muscle spasms, and burning left hand pain and muscle spasms. The injured worker complained of throbbing headaches rated at 7/10, dull/achy left shoulder pain rated at 6/10 to 7/10, left elbow pain and muscle spasms rated at 5/10 to 6/10, sharp stabbing left wrist pain and muscle spasms rated at 6/10 to 7/10, and burning left hand pain and muscle spasms rated at 6/10. Physical examination of the shoulder revealed tenderness at the supra and infraspinatus and subscapular muscles, decreased range of motion, and Apley's drop was positive. Elbow examination: there was tenderness over the left medial and lateral epicondyle, decreased range of motion, Cozen's, Tinel's, and Mill's tests were positive. Wrist examination: there was tenderness at TFC, carpal bones, thenar, hypothenar eminence, decreased range of motion, Tinel's, Finkelstein's, negative, and TFCC was positive. Hand examination: there was generalized tenderness at the hands and fingers with full range of motion, decreased sensation to pinprick, and light touch was intact, and motor strength was 4/5. Diagnoses included post-concussion syndrome, headache, dizziness, left shoulder osteoarthritis, left shoulder bicipital tenosynovitis, left elbow sprain/strain rule out derangement, left wrist sprain/strain rule out derangement, status post crush injury of the left hand, left hand sprain/strain, and left TFCC tear. The Request for Authorization dated 06/24/2014 was for

Physical Therapy, Neurologist Consultation, Terocin Patches, Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclobenzaprine Topical Gel, and Ketoprofen Cream. The rationale for medications was for the injured worker's pain relief and the neurologist consult was for the injured worker's headaches. The rationale for physical therapy was the injured worker was to continue physical therapy and acupuncture treatment for the left shoulder, elbow, wrist, hand, and fingers at a frequency of 3 times per week for a period of 6 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

18 Physical therapy visits for left hand, finger: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical/ Occupational Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The request is not medically necessary. The California MTUS Guidelines may support up to 10 visits of physical therapy for the treatment of unspecified myalgia and myositis to promote functional improvement. The documents submitted indicated the injured worker is already attending physical therapy and acupuncture treatment. Additionally, the request will exceed the recommended amount of visits per the guidelines. Furthermore, the provider failed to indicate outcome measurements, long-term functional goals, and home exercise regimen were not provided for the injured worker. Given the above, the request for 18 Physical Therapy Visits for the Left Hand, Finger is not medically necessary.

1 Neurologist consultation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 254.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Pain (Chronic), Office Visits.

Decision rationale: The request for a Neurologist Consultation is not medically necessary. Per the Official Disability Guidelines (ODG), office visits are recommended based on patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. In addition, the documents failed to indicate longevity of medication usage for the injured worker. There is a lack of documentation of long-term goals regarding functional improvement. Furthermore, the provider failed to indicate how long the injured worker has been having headaches. Given the above, the request for 1 Neurologist consultation is not medically necessary.

Terocin patches QTY Unspecified: Upheld

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

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

Decision rationale: The request for the Terocin patches QTY unspecified is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) Guidelines state that "topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety." The guidelines also state that "any compounded product contains at least one drug (or drug class) that is not recommended." Terocin ointment contains Lidocaine 4% and Menthol 4%. The guidelines state that "there are no other commercially approved topical formulation of Lidocaine (whether creams, lotions, or gels) that are indicated for neuropathic pain other than Lidoderm." The proposed ointment contains Lidocaine. Furthermore, there was no documentation of outcome measurements of physical therapy, pain management, or surgery. Additionally, the request lacked quantity, frequency and duration and location where the Terocin Patch would be applied. As Terocin Patches contain Lidocaine, which is not recommended, the proposed compounded product is not recommended. As such, the request for Terocin Patches QTY Unspecified is not medically necessary.

Deprizine QTY and mg Unspecified: 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 Proton pump inhibitors Page(s): 68-69.

Decision rationale: The request is not medically necessary. Prilosec is recommended for patients taking NSAIDs who are at risk of gastrointestinal events. The documentation submitted did not indicate the injured worker having gastrointestinal events. The provider failed to indicate the frequency and quantity medication on the request that was submitted. In addition, the provider failed to indicate long-term functional goals or medication pain management outcome measurements for the injured worker. Furthermore, the request lacked frequency, quantity, and duration .Given the above, the request for Deprizine (dosage and frequency unspecified) is not medically necessary.

Dicopanol QTY and mg Unspecified: 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 (ODG) Pain (Chronic) Insomnia Treatment.

Decision rationale: The request is not medically necessary. The Official Disability Guidelines (ODG) state that "Over-the-counter medications: such as Dicopanal are sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine). Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. Side effects include urinary retention, blurred vision, orthostatic hypotension, dizziness, palpitations, increased liver enzymes, drowsiness, dizziness, grogginess, and tiredness." The documents submitted for review failed to indicate the long-term functional goals for the injured worker to include medication management. The request failed to indicate frequency, quantity, and duration of medication. Given the above, the request for Dicopanol (Dosage and Frequency Unspecified) is not medically necessary.

Fanatrex QTY and mg Unspecified: 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 Gabapentin Page(s): 16.

Decision rationale: The request for Fanatrex is not medically necessary. The California MTUS Guidelines indicate that Gabapentin is shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. There is a lack of documentation of efficacy and functional improvement with the use of this medication. In addition, it was not indicated how long the injured worker had been utilizing this medication. Moreover, the request does not indicate a frequency or quantity for this medication. Therefore, the request for Fanatrex is not medically necessary.

Synapryn QTY and mg Unspecified: 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, Tramadol Page(s): 78, 113.

Decision rationale: The request for Synapryn is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) Guidelines do not recommend Tramadol as a first-line oral analgesic. The criteria for use for ongoing- management of opioids include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. There was lack of evidence of opioid medication management and average pain, intensity of pain, or longevity, of pain relief. In addition, the request does not include the frequency. In addition, there lack of evidence of outcome measurements of conservative care such as, physical therapy or home exercise regimen outcome improvements noted for the injured worker. The documentation submitted for review there was no a urine drug screen submitted to indicate Opioids compliance for the injured worker. The request submitted failed to indicate

frequency, quantity, and duration of medication. As such, the request for Synapryn Unspecified is not medically necessary.

Tabradol QTY and mg Unspecified: 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 requested service is not medically necessary. The California (MTUS) Chronic Pain Medical Guidelines recommends Flexeril as an option, using a short course therapy. Cyclobenzaprine (Flexeril) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. There is also a post-op use. The addition of Cyclobenzaprine to other agents is not recommended. Cyclobenzaprine-treated patients with fibromyalgia were 3 times as likely to report overall improvement and to report moderate reductions in individual symptoms, particularly sleep. Cyclobenzaprine is closely related to the tricyclic antidepressants and amitriptyline. The documentation submitted lacked evidence of outcome measurements of conservative care such as prior physical therapy sessions and medication pain management. There was lack of documentation provided on long term-goals of functional improvement of her home exercise regimen. In addition, the request lacked frequency, quantity, and duration of the medication. As such, the request for Tabradol is not medically necessary.

Cyclobenzaprine Topical Gel QTY and mg Unspecified: Upheld

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

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

Decision rationale: The California (MTUS) Chronic Pain Medical Guidelines state "topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety, primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. 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 other muscle relaxant as a topical product. The documents submitted failed to indicate outcome measurements of conservative care such as, physical therapy, pain medication management, and home exercise regimen. In addition, the request lacked duration, frequency, and location where topical cream is supposed to be applied on injured worker. Given the above, the request is not supported by the

guidelines noting the safety or efficacy of this medication. The request for Cyclobenzaprine Topical Gel is not medically necessary.

Ketoprofen cream QTY and mg Unspecified: Upheld

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

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

Decision rationale: The California (MTUS) Chronic Pain Medical Guidelines state "topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety, primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Non-steroidal ant inflammatory agents (NSAIDs) efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The documents submitted did not lack evidence of outcome measurements of conservative care such as, physical therapy, pain medication management, and home exercise regimen. In addition the request lacked duration, frequency and location where topical is supposed to be applied on injured worker. Given the above, the request is not supported by the guidelines noting the safety or efficacy of this medication. The request for Ketoprofen Cream is not medically necessary.