

Case Number:	CM14-0020392		
Date Assigned:	04/25/2014	Date of Injury:	03/25/2007
Decision Date:	07/25/2014	UR Denial Date:	02/12/2014
Priority:	Standard	Application Received:	02/18/2014

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 & Rehabilitation; has a subspecialty in Sports Medicine 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 52-year-old male who reported an injury on March 25, 2007 due to cumulative trauma while performing normal job duties. The injured worker developed bilateral carpal tunnel syndrome. The injured worker's treatment history included a right carpal tunnel release, and left carpal tunnel release. The injured worker was evaluated on January 27, 2014. It was documented that the injured worker had continued pain, swelling, and complaints of weakness of the right wrist. The injured worker had undergone right carpal tunnel release in December 2013. Physical findings included wrist pain rated at a 7/10 with residual numbness and weakness that was considered improving. The injured worker had a positive Tinel's sign of the left hand. No signs of infection of surgical incisions of the right hand with tenderness and slight swelling. The injured worker's diagnoses included headaches, cervical sprain, cervical radiculopathy, myalgia and myositis, elbow, hand and wrist sprain/strain, carpal tunnel syndrome, shoulder sprain, muscle spasms, anxiety, and sleep disorder. The injured worker's treatment plan included acupuncture, adjunctive physiotherapies, an MRI of the bilateral wrists, and a referral to a pain management physician.

IMR ISSUES, DECISIONS AND RATIONALES

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

PERIODIC UA TOXICOLOGY EVALUATION: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43.

Decision rationale: The requested periodic UA toxicology evaluation is not medically necessary or appropriate. The Chronic Pain Medical Treatment Guidelines recommend random urine drug screens for patients on chronic opioid usage. Clinical documentation does indicate that the injured worker is taking Synapryn which contains tramadol. This would require ongoing urine drug screening. However, clinical documentation fails to identify whether the injured worker is engaged in a opioid pain contract. A risk assessment of the injured worker's risk factors for aberrant behavior is also not provided. Clinical documentation does not include when the injured worker's last urine drug screen was complete and the results of that urine drug screen. As such, the request is not medically necessary or appropriate.

PHYSIOTHERAPY FOR THE CERVICAL SPINE, RIGHT AND LEFT WRIST, #18:
Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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

Decision rationale: The requested physical therapy for the cervical spine and right and left wrists (#18) is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has previously participated in physical therapy. The injured worker should be well versed in a home exercise program. The Chronic Pain Medical Treatment Guidelines recommend that injured workers be transitioned into a home exercise program to maintain improvement levels obtained during skilled physical therapy. There are no factors to preclude further progress of the patient while participating in a self-directed, self-managed home exercise program. As such, the request is not medically necessary or appropriate.

TEROCIN PATCHES: Upheld

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

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

Decision rationale: The requested Terocin patches are not medically necessary or appropriate. The requested medication is a compounding medication that contains menthol, methyl salicylate, and capsaicin. The Chronic Pain Medical Treatment Guidelines do not recommend the use of capsaicin as a topical analgesic unless all other first line chronic pain management treatments have been exhausted. The clinical documentation does not provide any evidence that the injured worker has failed to respond to first line medications to include anticonvulsants and antidepressants. Therefore, continued use of this medication would not be supported.

Additionally, the request as it is submitted does not identify a frequency of treatment or dosage. In the absence of this information, the appropriateness of the request cannot be determined. As such, the request is not medically necessary or appropriate.

KETOPROFEN 20% 120GMS: Upheld

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

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

Decision rationale: The requested ketoprofen (20%) 120gm is not medically necessary or appropriate. The Chronic Pain Medical Treatment Guidelines do not recommend the topical use of ketoprofen as it is not FDA approved to treat neuropathic pain. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the request is not medically necessary or appropriate.

CYCLOPHENE 5% 120GMS: Upheld

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

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

Decision rationale: The requested cyclophene (5%) 120gm is not medically necessary or appropriate. The requested medication contains cyclobenzaprine. The Chronic Pain Medical Treatment Guidelines do not recommend the use of topical muscle relaxants. There is little scientific evidence to support the efficacy and safety of this medication. There are no exceptional factors noted within the documentation to support extending treatment beyond guidelines recommendations. As such, the request is not medically necessary or appropriate.

DICOPANOL 5MG: Upheld

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

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 Treatments.

Decision rationale: The requested dicopanol 5mg is not medically necessary or appropriate. The requested medication is a compounded medication and contains diphenhydramine. The Chronic Pain Medical Treatment Guidelines do not address sedating antihistamines for insomnia. The Official Disability Guidelines recommend short durations of treatment with sedating

antihistamines for insomnia related complaints. However, the clinical documentation submitted for review does not provide an adequate assessment of the injured worker's sleep hygiene. There is no indication that the injured worker would benefit from this medication. There is no documentation that the injured worker has not responded to non-pharmacological interventions. In addition, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

DEPRIZINE 5MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk.

Decision rationale: The requested deprizine 5 mg is not medically necessary or appropriate. The requested medication is a compounded medication that contains ranitidine. California Medical Treatment Utilization Schedule recommends gastrointestinal protectants for injured workers who are at risk for developing gastrointestinal events related to medication usage. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's gastrointestinal system to support that they are at significant risk for developing disturbances related to medication usage. Therefore, the use of this medication is not supported. Additionally, the request as it is submitted does not identify a frequency or duration of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested deprizine 5 mg is not medically necessary or appropriate

FANATREX 25MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epileptics.

Decision rationale: The requested fanatrex 25mg is not medically necessary or appropriate. The requested medication is a compounded medication that contains gabapentin. The Chronic Pain Medical Treatment Guidelines do recommend the use of anticonvulsants as a first line treatment in the management of chronic pain. However, the clinical documentation submitted for review does not provide any justification that the injured worker requires a liquid suspension and cannot tolerate traditional oral formulations of this medication. Additionally, the request as it is submitted does not clearly identify a quantity or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

SYNAPRYN 10MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate) and Opioids, On-Going Management.

Decision rationale: The requested Synapryn 10mg is not medically necessary or appropriate. The requested medication is a compounded medication that contains tramadol and glucosamine. The Chronic Pain Medical Treatment Guidelines do recommend the use of glucosamine for osteoarthritic pain related complaints. However, the use of opioids to include tramadol should be supported by ongoing assessments of functional benefit and symptom response. Clinical documentation fails to identify any functional benefit or pain relief resulting from medication usage. Therefore, the use of this medication would not be supported. Additionally, the request as it is submitted does not clearly identify a quantity or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

TABRADOL 1MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants.

Decision rationale: The requested Tabradol 1mg is not medically necessary or appropriate. The requested medication is a compounded medication that contains cyclobenzaprine. The Chronic Pain Medical Treatment Guidelines recommends short durations of treatment not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. The clinical documentation failed to identify that the injured worker was experiencing an acute exacerbation of chronic pain that would benefit from a muscle relaxant. Additionally, the request as it is submitted does not clearly identify a frequency or quantity of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

CHIROPRACTIC THERAPY TO THE CERVICAL SOINE, RIGHT AND LEFT WRIST, #18: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58.

Decision rationale: The requested chiropractic therapy to the cervical spine right and left wrists (#18) is not medically necessary or appropriate. The clinical documentation does indicate that injured worker has previously participated in manual manipulation of the requested body parts. However, the Chronic Pain Medical Treatment Guidelines do not recommend manual manipulation of the wrists. Therefore, the request itself would not be considered medically appropriate. As such, the request is not medically necessary or appropriate.