

Case Number:	CM14-0023384		
Date Assigned:	05/12/2014	Date of Injury:	05/14/2004
Decision Date:	07/15/2014	UR Denial Date:	01/21/2014
Priority:	Standard	Application Received:	02/24/2014

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 Occupational Medicine and is licensed to practice in California. 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 patient is a 60 year old female who was injured on 05/14/2004. The mechanism of injury is unknown. The patient underwent an arthrotomy of the right elbow with a lateral release of the right elbow on 10/01/2013. Prior treatment history has included intra-articular cortisone injection under ultrasound guidance to the right elbow. X-rays of the bilateral shoulders and bilateral humerus revealed no progression of degenerative changes. A report dated 02/20/2014 states the patient presents for follow-up of her visit of her bilateral elbows and bilateral shoulders. She reported she has left elbow pain but the injection she received at the last visit has made her pain better. She also reports right shoulder discomfort. She rates her pain as a 5 out of 10. There are no objective findings documented. The treatment and plan include requests for additional physical therapy and an interferential unit for a 30-60 day rental and purchase if effective along with accessories to maintain long-term care. The patient is diagnosed with lateral epicondylitis. On a report dated 01/09/2014, the patient reports she feels better but still complains of pain in the right elbow causing her to wake up at night. She reported she would like another physical therapy prescription. There are no physical findings for review. The patient was given a prescription for Dyotin SR 250 mg #60 for nerve pain, Flurbitac 100/100 mg #60 for pain and inflammation with H2 blocker for acid prevention, Theraflex cream 180 mg for muscle spasm, Keratek Gel 4 oz. bottle-pain/inflammation and Vicosetron 10/300 #40 analgesic. The patient was instructed to return on 02/20/2014. Prior Utilization Review dated 01/21/2014 states the request for Vicosetron, Keratek gel, Theraflex transdermal cream, Dyotin 250/10 mg; and Flurbitac 100/100 mg is non-certified as medical necessity has not been established.

IMR ISSUES, DECISIONS AND RATIONALES

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

VISOSETRON CAPSULES: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47,Chronic Pain Treatment Guidelines.

Decision rationale: According to the California MTUS guidelines, using medications in the treatment of pain requires a thorough understanding of the mechanism underlying the pain as well as to identify comorbidities that might predict an adverse outcome. As stated on page 47 of the ACOEM Practice Guidelines, consideration of comorbid conditions, side effects, cost, and efficacy of medication versus physical methods and provider and patient preferences should guide the physician's choice of recommendations. Choice of pharmacotherapy must be based on the type of pain to be treated and there may be more than one pain mechanism involved. The physician should tailor medications and dosages to the individual taking into consideration patient-specific variables such as comorbidities, other medications, and allergies. The physician should be knowledgeable regarding prescribing information and adjust the dosing to the individual patient. If the physician prescribes a medication for an indication not in the approved FDA labeling, he or she has the responsibility to be well informed about the medication and that its use is scientific and evidence-based. There is no sufficient medical literature or peer review that supports use of this medication. No specific rationale for this medication is provided, but it appears to be a narcotic analgesic. Medical records do not document functional improvement or objective pain reduction from use of this medication. Medical necessity is not established.

KERATEK GEL: Upheld

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

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

Decision rationale: According to the California MTUS guidelines, topical NSAIDs may be recommended for short-term treatment of osteoarthritis in joints amenable to topical therapy. Keratek cream is a compound analgesic that contains the ingredient methyl salicylate. The patient appears to be prescribed this medication on a chronic basis. Further, there is no rationale provided for use of this medication, no discussion of osteoarthritis, and no discussion of efficacy. Medical necessity is not established.

THERAFLEX TRANSDERMAL CREAM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate) Page(s): 50.

Decision rationale: According to the California MTUS guidelines, topical analgesics may be recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Theraflex cream appears to be a proprietary blend topical analgesic containing multiple compounds including methyl salicylate. As discussed above, the medical necessity for use of topical methyl salicylate is not established in this patient. Further, the guidelines do not specifically recommend any of the compounds present in this formulation. Medical necessity is not established.

DYOTIN 250/10MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-19.

Decision rationale: According to the California MTUS guidelines, Dyotin SR (Gabapentin) has been shown to be effective for treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. In this case, the medical records at the time of request for this medication fail to document symptoms or signs, by examination or diagnostics, of neuropathy. Further, there is no discussion of efficacy of this medication in this patient. Medical necessity is not established.

FLURBITAC 100/100MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, GI symptoms & cardiovascular risk Page(s): 67-69.

Decision rationale: Flurbitac appears to be a combination product containing an NSAID and H2 antagonist. According to MTUS guidelines, NSAIDs are recommended in osteoarthritis at the lowest dose for the shortest period possible in patients with moderate to severe pain. H2 antagonist is recommended for patients who are at intermediate risk of GI events due to NSAID use. There is no discussion of osteoarthritis in the available records or rationale provided for use of this medication. There patient's last surgery on 10/01/13 was about 3 months prior to this request. There is no discussion of improvement in pain or function from use of this medication. Medical necessity is not established.