

Case Number:	CM14-0188569		
Date Assigned:	11/19/2014	Date of Injury:	05/29/2013
Decision Date:	01/20/2015	UR Denial Date:	11/06/2014
Priority:	Standard	Application Received:	11/12/2014

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 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 51 year old male with a date of injury of 05/29/13. The treating physician report dated 10/14/14 indicates that the patient presents with pain affecting the neck, left shoulder, left elbow, left wrist, left index finger, and psyche. The physical examination findings reveal, patient is frustrated by injury; left index finger status open reduction and internal fixation (ORIF) with residual pain and a rate of 7/10 on a pain analog scale which is aggravated by gripping, grasping, etc.; left wrist burning and pain with a scale of 7/10 on a pain analog scale; both neck, should and elbow have a consistent pain of 7/10 on a pain analog scale and are aggravated by gripping, grasping, etc. The current diagnoses are cervical spine sprain/strain rule out herniated nucleus pulposus (HNP); rule out cervical radiculopathy; left should and elbow sprain/strain rule out internal derangement; left wrist sprain/strain rule out carpal tunnel syndrome; status post left index finger open reduction and internal fixation (ORIF) with residual pain; anxiety, mood, and sleep disorders; and stress. The utilization review report dated 11/05/14 denied the request for Functional Capacity Evaluations, Terocin Patches, Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclobenzaprine, and Ketoprofen Cream based on lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Capacity Evaluations: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 125.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page 137-138

Decision rationale: The current request is for Functional Capacity Evaluations. The treating physician does indicate in their report dated 10/14/14 indicates that the evaluation is for work modification requests. The MTUS Guidelines do not discuss functional capacity evaluations. ACOEM chapter 7, was not adopted into MTUS, but would be the next highest-ranked standard according to LC4610.5 (2)(B). ACOEM does not appear to support functional capacity evaluations unless the employer or claims administrator makes the request following the treating physician making work restriction recommendations. ACOEM states, "The examiner is responsible for determining whether the impairment results in functional limitations and to inform the examinee and the employer about the examinee's abilities and limitations. The physician should state whether the work restrictions are based on limited capacity, risk of harm, or subjective examinee tolerance for the activity in question. The employer or claim administrator may request functional ability evaluations, also known as functional capacity evaluations, to further assess current work capability." In this case the employer or claims administrator is not requesting an FCE. The guidelines do not support the current request. Therefore, this request is not medically necessary.

Terocin Patches: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

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

Decision rationale: The current request is for Terocin Patches. Terocin is a compounded medication, which includes Lidocaine, Capsaicin, Salicylates and Menthol. MTUS guidelines page 112 states, "topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica)." When reading the Official Disability Guidelines, it specifies that Lidoderm patches are indicated as a trial if there is "evidence of localized pain that is consistent with a neuropathic etiology." Official Disability Guidelines further requires documentation of the area for treatment, trial of a short-term use with outcome documenting pain and function. In this case, the treating physician has failed to document that the patient has localized peripheral pain and or has failed a trial of SNRI or anti-epilepsy drug. Therefore, this request is not medically necessary.

Deprizine (strength and quantity unknown): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Compound Drugs

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-68.

Decision rationale: The current request is for Deprizine. Deprizine (Ranitidine) is used to treat and prevent heartburn with acid indigestion, gastroesophageal reflux disease (GERD) and conditions that cause your stomach to make too much acid. The MTUS Guidelines states, "Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." In this case, there is no documentation that the patient is experiencing any GI issues and the current request is for an unknown dosage and duration of Deprizine. Therefore, this request is not medically necessary.

Dicopanол (strength and quantity unknown): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Compound Drugs

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Online Mental Illness & Stress Chapter: Insomnia treatment

Decision rationale: The current request is for Dicopanол. Dicopanол contains diphenhydramine and other proprietary ingredients. The Official Disability Guidelines state that there is no support of sedating antihistamines like diphenhydramine on a long-term basis has been suggested for insomnia. In this case, the treating physician has not indicated duration or quantity for this request, which renders the prescription invalid from an Independent Medical Review standpoint. Therefore, this request is not medically necessary.

Fanatrex (strength and quantity unknown): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Compound Drugs

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 49.

Decision rationale: The current request is for Fanatrex (Gabapentin). The MTUS Chronic Pain Medical Treatment Guidelines support the usage of Gabapentin for the treatment of radicular pain. In this case, the treating physician has prescribed Fanatrex and there is no history of radicular pain or physical examination findings of radiculopathy. The treating physician has failed to document the condition that this medication is intended to be used for treatment. Additionally, the current request is for an unknown dosage and duration rendering the prescription invalid. Therefore, this request is not medically necessary.

Synapryn (strength and quantity unknown): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 50, 84. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Compound Drugs

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-96, 113.

Decision rationale: The current request is for Synapryn. Synapryn is an oral suspension that contains Tramadol and Glucosamine as well as other proprietary ingredients. The MTUS Guidelines do support Tramadol for chronic moderately severe pain, but it is not recommended as a first-line oral analgesic. In this case, the treating physician has not indicated duration or quantity for this request, which renders the prescription invalid. Additionally, this request appears to be an initial request for an opioid and MTUS requires documentation of several criteria that need to be documented before beginning opioids which were not found in the records provided. Therefore, this request is not medically necessary.

Tabradol (strength and quantity unknown): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Compound Drugs

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

Decision rationale: The current request is for Tabradol. Tabradol contains Cyclobenzaprine, Methylsulfonylmethane and other proprietary ingredients. The MTUS guidelines support the usage of Cyclobenzaprine for a short course of therapy, not longer than 2-3 weeks. In this case, the treating physician has not indicated duration or quantity for this request, which renders the prescription invalid and is not supported by MTUS as there is no specific duration of short term usage. Therefore, this request is not medically necessary.

Cyclobenzaprine (strength and quantity unknown): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66, 113.

Decision rationale: The current request is for Cyclobenzaprine. The treating physician does not indicate in their report dated 10/14/14 indicate what the current request would be treating. The MTUS guidelines support the usage of Cyclobenzaprine (Flexeril) for a short course of therapy, not longer than 2-3 weeks. MTUS is very specific that Cyclobenzaprine is only to be used for a

short course of treatment and there is no documentation from the provider as to what dosage or duration this request is for. Therefore, this request is not medically necessary.

Ketoprofen Cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

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

Decision rationale: The current request is for Ketoprofen Cream. The treating physician does not indicate in their report dated 10/14/14 indicate what the current request would be treating. There is no documentation of the dosage, frequency or duration of this prescription. MTUS Guidelines support use of NSAID topicals for peripheral arthritis and tendonitis. Ketoprofen is not currently FDA approved for a topical application. In this case, the treating physician has not diagnosed the patient with arthritis or tendinitis and the provider has failed to document the dosage, frequency or duration of usage for this medication. Therefore, this request is not medically necessary.