

Case Number:	CM14-0132559		
Date Assigned:	08/22/2014	Date of Injury:	04/28/2005
Decision Date:	09/24/2014	UR Denial Date:	07/23/2014
Priority:	Standard	Application Received:	08/19/2014

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 Anesthesiology and Pain Medicine and is licensed to practice in Florida. 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 72-year-old female who reported an injury on 04/28/2005 due to a work-related injury. The injured worker had a history of neck, bilateral shoulder, bilateral forearms, bilateral wrists, lower back, and bilateral knee pain. The injured worker had diagnoses of cervical musculoligamentous strain/sprain, facet degeneration and foraminal stenosis, right shoulder impingement syndrome, periscapular strain, left shoulder impingement syndrome, bilateral wrist tendinitis, lumbar musculoligamentous strain/sprain. The prior surgeries included a rotator cuff repair with arthropathy dated 02/2007. The MRI dated 12/03/2007 of the cervical spine revealed degenerative disc seen at the C5-6, moderate right facet hypertrophy at the C2-3, C6-7, and the C7-T1 levels. The MRI of the lumbar spine dated 03/18/2011 revealed mild hypertrophic changes at the facet joints bilaterally to the L1 and L2, disc desiccation and hypertrophic changes in the facet joints bilaterally at the L2-3, disc protrusion encroaching into the supraspinatus articular gutters with mild narrowing at the neural foramina at the L3-4, mild narrowing at the L4-5. The past treatment included acupuncture, physical therapy, home exercise program, electro muscle stimulation unit, and medication. The physical examination dated 09/18/2013 of the lower back revealed flexion to 16 degrees and extension 10 degrees. There was no tenderness to palpation over the vertebra or bony process. Straight leg raising test was negative bilaterally. The physical examination of the neck revealed full range of motion with forward flexion, extension, lateral rotation and lateral bending. The injured worker was guarded with all motion. There was tenderness to all joints. The physical examination of the upper extremities revealed shoulder symmetric with full and unrestricted range of motion to the forearms, wrists and hands. There was mild weakness of the left shoulder with mild tenderness of the right shoulder in the subacromial space. There was no tenderness to palpation over the acromioclavicular joint. There was a negative Tinel's test. Medication included the Depazine,

Dicopanol, Fanatrex, Synapryn, Tabradol, cyclobenzaprine, and Terocin patches. The treatment plan included to refill medication. The request for authorization dated 08/22/2014 was submitted with documentation. The rationale for the medication was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Deprizine (unspecified dose,frequency): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 70.

Decision rationale: The request for Deprizine is not medically necessary The California MTUS guidelines indicate that per Package inserts for NSAIDs it is recommended to perform periodic lab monitoring of a CBC and chemistry profile (including liver and renal function tests). There has been a recommendation to measure liver transaminases within 4 to 8 weeks after starting therapy, but the interval of repeating lab tests after this treatment duration has not been established. The guidelines indicate a CBC and chemistry profile should be monitoring of a CBC and chemistry profile within 4 to 8 week after starting therapy. The request did not address frequency, duration or dosage. As such, the request is not medically necessary.

Dicopanol (unspecified dose,frequency): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines NSAIDS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASMODICS Page(s): 64.

Decision rationale: The request for Dicopanol is not medically necessary. The California MTUS Guidelines indicate that the mode of action is not clearly understood. Effects are thought to be secondary to analgesic and anticholinergic properties. The mode of action is not clearly understood. The request did not address the dose, frequency or duration. As such, the request is not medically necessary.

Fanatrex (unspecified dose,frequency): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-22.

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 post herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The clinical notes did not indicate that the injured worker had a diagnosis of diabetes or neuropathy or postherpetic neuralgia. The request did not address the dose, frequency or duration. As such, the request is not medically necessary.

Synapryn (unspecified dose,frequency): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78,93-94,113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol; Ongoing management Page(s): 82, 93, 94, 113; 78.

Decision rationale: The request for Synapryn is not medically necessary. The California MTUS states Central analgesics drugs such as Tramadol (Ultram) are reported to be effective in managing neuropathic pain and it is not recommended as a first-line oral analgesic. California MTUS recommend that there should be documentation of the 4 A's for Ongoing Monitoring including analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. The clinical note did not indicate the injured worker took any medication, did not provide a functional deficit with and without the medication or any adverse side effects or aberrant drug taking behavior. The request did not address the dosage, frequency or duration. As such, the request is not medically necessary.

Tabradol (unspecified dose,frequency): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment 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 (Chronic) Muscle relaxants (for pain).

Decision rationale: The request for Trabradol is not medically necessary. The Official Disability Guidelines recommend for a short course of therapy. Indicated for short-term (less than two weeks) treatment of acute LBP and for short-term treatment of acute exacerbations in patients with chronic LBP. The clinical notes did not indicate the length of time that the injured worker had been taking tramadol; however, guidelines indicate for less than 2 weeks for acute lower back pain. The request did not address the dose, frequency or duration. As such, the request is not medically necessary.

Cyclobenzaprine (unspecified dose,frequency): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 41,64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41, 64.

Decision rationale: The request for cyclobenzaprine is not medically necessary. The California MTUS states that Cyclobenzaprine (Flexeril) is recommended for a short course of therapy. Flexeril is more effective than placebo in the management of back pain; however, 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. This medication is not recommended to be used for longer than 2-3 weeks. Efficacy. The guidelines recommend cyclobenzaprine for no longer than 2 to 3 weeks to manage back pain. The clinical notes did not indicate the length of time that the injured worker had been taking the cyclobenzaprine or if she still is taking it. The request did not indicate the dose, frequency or duration. As such, the request is not medically necessary.

Terocin patches (unspecified dose,frequency): Upheld

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

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

Decision rationale: The request for Terocin patches is not medically necessary. The CA MTUS states that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety; also, that they are 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. Many agents are compounded as monotherapy or in combination for pain control; however, there is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended, therefore, is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. The request did not specify the dose, frequency, or duration. As such, the request is not medically necessary.