

Case Number:	CM15-0077105		
Date Assigned:	04/28/2015	Date of Injury:	07/31/2013
Decision Date:	06/29/2015	UR Denial Date:	03/26/2015
Priority:	Standard	Application Received:	04/22/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 female, who sustained an industrial injury on 7/31/2013, due to cumulative trauma. The injured worker was diagnosed as having headaches, cervical spine herniated nucleus pulposus, right shoulder rotator cuff tear, status post right carpal tunnel release surgery with residual pain, sleep disorder, mood disorder, anxiety, insomnia, depression, stress, and fatigue. Treatment to date has included diagnostics, physical therapy, shockwave therapy, and medications. Terocin patches were requested for pain relief on 10/13/2014, at which time pain was rated 7-8/10, and the current use of medication was not noted. Currently (2/09/2015), the injured worker complained of headaches, radicular neck pain, right shoulder pain, and right wrist pain. Pain was rated 7-8/10. She stated that medications offered temporary relief of symptoms and current medication regime was not noted. A letter of medical necessity, dated 2/27/2015, was noted for Dicopanol 5mg/ml oral suspension 150 ml (1 ml at bedtime, qty 1), Deprizine 5mg/ml oral suspension 250 ml (10ml daily, qty 1), Fanatrex 25mg/ml oral suspension 250ml (5ml three times daily, qty 1), Synapryn 10mg/ml oral suspension 500ml (5ml three times daily, qty 1), and Tabradol 1mg/ml oral suspension 250ml (5ml 2-3 times daily, qty 1) was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Deprizine (unspecified dosage/ qty): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: Deprizine contains ranitadine and other proprietary ingredients. Ranitadine is an H2 blocker and like a PPI can be utilized to treat dyspepsia secondary to NSAID therapy. MTUS states "Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low- dose ASA)." MTUS also states that, "Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44)." The medical documents provided do not establish the patient has having documented GI bleeding, perforation, peptic ulcer, high dose NSAID, treatment of dyspepsia secondary to NSAID therapy or other GI risk factors as outlined in MTUS. Additionally, the treating physician does not specify dosage or quantity of this request. As such, the request for Deprizine (unspecified dosage/qty) is not medically necessary.

Terocin Patches (unspecified dosage/ qty): 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

Decision rationale: MTUS and ODG recommends usage of topical analgesics as an option, but also further details primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The medical documents do not indicate failure of antidepressants or anticonvulsants. Terocin lotion is topical pain lotion that contains lidocaine and menthol. ODG states regarding lidocaine topical patch, "This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia." Medical documents do not document the patient as having post-herpetic neuralgia. Additionally, Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The treating physician did not document a trial of first line agents and the objective outcomes of these treatments. MTUS states regarding topical analgesic creams, "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 is not recommended." In this case, topical lidocaine is not indicated. Additionally, the treating physician does not specify dosage or quantity of this request. As such the request for Terocin Patches (unspecified dosage/qty) is not medically necessary.

Dicopanol (unspecified dosage/ qty): Upheld

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

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

Decision rationale: MTUS is silent on the use of diphenhydramine. ODG discusses the use of diphenhydramine as an over the counter sleep aid in the chronic pain segment. For insomnia ODG recommends that pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. (Lexi-Comp, 2008) Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. The specific component of insomnia should be addressed: (a) Sleep onset; (b) Sleep maintenance; (c) Sleep quality; & (d) Next-day functioning. ODG recommends that, "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." There is documentation of diagnoses to include mood disorder, anxiety and depression. Based on ODG guidelines a trial of anti-depressants to treat the underlying psychiatric illness should have occurred. Additionally, the treating physician does not specify dosage or quantity of this request. As such, the request for Dicopanol (unspecified dosage/ qty) is not medically necessary.

Fanatrex (unspecified dosage/ qty): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs Page(s): 16-22. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Anti-epilepsy drugs (AEDs) for pain, Gabapentin (Neurontin ½).

Decision rationale: The MTUS considers Gabapentin as a first-line treatment for neuropathic pain and effective for the treatment of spinal cord injury, lumbar spinal stenosis, and post op pain. MTUS also recommends a trial of Gabapentin for complex regional pain syndrome. ODG states "Recommended Trial Period: One recommendation for an adequate trial with Gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. (Dworkin, 2003) The patient should be asked at each visit as to whether there has been a change in pain or function. Current consensus based treatment algorithms for diabetic neuropathy suggests that if inadequate control of pain is found, a switch to another first-line drug is recommended." Additionally, ODG states that Gabapentin "has been 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." The treating physician does not document neuropathic pain. The treating physician did not document improved functionality and decreased pain after starting Fanatrex. Based on the clinical documentation provided, there

is no evidence that after starting a trial of Fanatrex that the patient was asked at each subsequent visit if the patient had decreased pain and improved functionality. Additionally, the treating physician does not specify dosage or quantity of this request. As such, without any evidence of neuropathic type pain, the request for Fanatrex (unspecified dosage/qty) is not medically necessary.