

<b>Case Number:</b>	CM14-0052503		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	07/31/2013
<b>Decision Date:</b>	09/17/2015	<b>UR Denial Date:</b>	04/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/21/2014

### 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. 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: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 23 year old, male who sustained a work related injury on 7/31/13. The diagnosis has included right wrist strain/sprain. Treatment has included medication. In the PR-2 dated 10/31/14, the injured worker complains of burning right wrist pain and muscle spasms. The pain is described as frequent to intermittent and mild to moderate. He rates the pain a 5/10. He states his condition has worsened since last visit. The treatment plan is a referral for a functional capacity evaluation and for refills of medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 functional Capacity Evaluations: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines Chapter 7, Independent Medical Examinations and Consultations (2004) pg 137-138 and on the Official Disability Guidelines, Fitness for Duty.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Functional Capacity Evaluation and Other Medical Treatment Guidelines ACOEM Chapter 7, page 137.

**Decision rationale:** Per the ODG, functional capacity evaluations (FCE) are recommended prior to admission to work hardening programs, with preference for assessments tailored to a specific job. Not recommended as a routine use as part of occupational rehab or screening, or generic assessments in which the question is whether someone can do any type of job. Consider an FCE if: Case management is hampered by complex issues such as prior unsuccessful return to work attempts, conflicting medical reporting on precaution and/or fitness for modified work, and injuries that require detailed exploration of the workers abilities. There is no mention of previous failed return to work attempts. There is no mention of failure to respond to formal physical therapy. At this time, there is a lack of supportive documentation to warrant an FCE. This request is not medically necessary.

**Tabradol 1mg/ml 250ml, #1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80, 93-94, 124.

**Decision rationale:** The California MTUS states Tabradol is an agent containing Cyclobenzaprine, and recommends use for short periods of time. It also contains methylsulonylmethane, which can be used topically for regional inflammatory reactions, and should be considered investigational, used only when other therapies have failed. There is no mention as to why the injured worker requires this particular suspension over oral tablet alternatives. The injured workers pain has worsened, despite the medications he is utilizing for his pain. Long term use is not recommended. At this time, the request is not medically necessary.

**Deprizine 15mg/ml oral suspension 250ml #1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PPI Page(s): 68-69.

**Decision rationale:** According to the MTUS Chronic Pain Guidelines, Proton Pump Inhibitors are used to treat symptoms of gastritis, peptic ulceration, acid reflux, and/or dyspepsia related to non-steroidal anti-inflammatories (NSAIDs). California MTUS does not specifically address Deprizine, however, there is no mention in the documentation of any of the above conditions that would warrant certifying this medication. At this time, the request is not medically necessary.

**Dicopanol 5mg/ml 420ml #1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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:** ODG notes that sedating anti-histamines have been suggested for sleep aids. Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. The FDA indications for diphenhydramine include use as an antihistaminic, in the management of motion sickness, and parkinsonism, and as a nighttime sleep aid. Dicopanol is liquid anti-histamine. There is no clear rationale for liquid form of this medication as opposed to oral capsule or tablet. There is no documented effectiveness of previous use of anti-histamine on sleep quality and mention of a lack of adverse effects from use of these agents. At this time, the request is not medically necessary.

**Fanatrex 25mg/ml 420ml #1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neuropathic Pain/Anti-epileptics Page(s): 16-21.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that anti-epilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. There should be documentation of pain relief, and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. There is no mention of improved outcomes with the use of anti-epileptics, or pain response to these agents. The request is not medically necessary.

**Terocin Patches: Upheld**

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

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

**Decision rationale:** Per MTUS guidelines, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anti-convulsants and/or anti-depressants have failed. The guidelines go on to state that when any compounded product

contains 1 medication that is not recommended, the compounded product as a whole is not recommended. Terocin contains topical Lidocaine, which is approved in patch form, and for use in Post-Herpetic Neuralgia. At this time, the request is not medically necessary.