

<b>Case Number:</b>	CM13-0040248		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	08/27/2013
<b>Decision Date:</b>	02/21/2014	<b>UR Denial Date:</b>	10/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and Pulmonary Diseases 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 physician 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 22-year-old male who reported an injury on 08/27/2013. The mechanism of injury was a heavy container falling onto his head. The patient continued to work after his injury without receiving treatment, despite reporting his injury several times. On 10/30/2013, the patient is noted to have been referred for physical therapy and chiropractic treatment; no notes were included for review. At this time, MRI of his left shoulder was obtained with no abnormal results; MRI of the cervical spine on 10/29/2013 revealed 1 mm to 2 mm posterior disc bulges at C3-7 without evidence of canal stenosis or neural foraminal narrowing. On physical examination dated 10/18/2013, the patient is noted to have subjective complaints of headaches, anxiety, depression, sleep difficulties, and pain that is aggravated by repetitive neck bending, repetitive carrying, repetitive hand and arm movements, and repetitive pushing and pulling. Physical examination on this date reveals non-specific tenderness and negative apprehension, supraspinatus resistance testing to the left shoulder with positive findings of Speed's and impingement testing. There was no documentation of loss of sensibility, abnormal sensation, or pain in the anterolateral shoulder and arm corresponding to the C5, C6, C7, and C8 dermatomes. There was also negative Spurling's test and normal muscle tone throughout with mild tenderness to the entire cervical spine. The patient did not have any deficits in cervical range of motion. On this date, he was also prescribed acupuncture therapy; it is unclear if this was ever followed through. The PR-2 note dated 10/25/2013 revealed decreased sensation to pinprick and light touch to an unknown dermatome and motor strength of 4/5 to the right shoulder. Neurological examination performed on 10/30/2013 revealed sensation to pinprick and light touch that is diminished to the C5, C6, C7, C8, and T1 dermatomes on the left upper extremity with motor strength of 4/5 in all

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Fanatrex:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epileptics Page(s): 16-19.

**Decision rationale:** California MTUS/ACOEM Guidelines recommend the use of antiepileptic drugs to treat neuropathic pain. Continuation of these medications should be based on at least a 30% to 50% reduction in pain during the trial period. For spinal cord injury with radiculopathy, gabapentin is recommended for use. The trial period should be 3 to 8 weeks for titration, then 1 to 2 weeks at a maximum tolerated dosage. The patient should be asked at each visit as to whether there has been a change in pain or function. The medical records provided for review did not specify how long the patient has been utilizing this medication; there is no discussion in any of the clinical notes provided regarding the patient's medications. Therefore, there is no evidence the patient has been safely titrated, how long the patient has been in his trial period, and no discussion of the results and effects the medication has on the patient's pain. The current request also does not provide a dosage and quantity; therefore, guideline compliance and medical necessity cannot be determined. As such, the request for Fanatrex is non-certified.

**Dicopanol:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [www.drugs.com](http://www.drugs.com)

**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 Treatment.

**Decision rationale:** California MTUS/ACOEM Guidelines do not specifically address the use of diphenhydramine; therefore, Official Disability Guidelines were supplemented. Official Disability Guidelines state over-the-counter medications such as sedating antihistamines (diphenhydramine), may be used as sleep aids. However, tolerance seems to develop within a few days and next day sedation is common. The current medical records submitted for review did not specifically detail the purpose for the use of Dicopanol. There was discussion regarding the patient's difficulties with sleep; however, there is no documentation as to when this medication was initiated or its efficacy. As such, the medical necessity cannot be determined at this time and the request for Dicopanol is non-certified.

**Deprizine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [www.drugs.com](http://www.drugs.com)

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

**Decision rationale:** California MTUS/ACOEM Guidelines state patients who are at high risk for gastrointestinal events can have adjunctive medication therapy to prevent GI ulcers, bleeding, or other adverse reactions. Although opioids can also cause stomach upset, these symptoms are likely to improve within a couple weeks of exposure. In the medical records provided for review, there was no discussion of the patient's risk factors for, or previous history of, GI events. As such, the medical necessity for this medication is not established and the request for Deprizine is non-certified.

**Tabradol:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Library of Medicine

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-65.

**Decision rationale:** California MTUS/ACOEM Guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. Tabradol in particular, is an antispasmodic that is used to decrease muscle spasm and is recommended for use of no longer than 2 to 3 weeks. This medication should be used after a first-line therapy, such as a tricyclic antidepressant, has been attempted. In the medical records provided for review, there is no discussion on when this treatment was initiated or the effects it has on the patient's pain and spasms. Without this information, guideline compliance and medical necessity cannot be established. As such, the request for Tabradol is non-certified.

**Synapryn:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [www.drugsdb.eu](http://www.drugsdb.eu)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

**Decision rationale:** California MTUS/ACOEM Guidelines recommend the use of opioids to treat chronic pain. Prior to initiation of opioid therapy, guidelines recommend baseline functional and pain levels be documented, as well as a written consent and pain agreement with urine drug screen provided. Ongoing management includes assessing the patient's current pain levels, least reported pain since last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Opioids and tramadol

have been suggested as a second-line treatment after a trial of tricyclic antidepressants have failed. Tramadol in particular, is not known to provide benefit past 3 months. The clinical record submitted for review did not provide any information regarding when this medication was initiated or the effects it has had on the patient's pain. As such, the medical necessity and guideline compliance cannot be established and the request for Synapryn is non-certified.

**Compounded Cyclophene 5%:** Upheld

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

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

**Decision rationale:** California MTUS/ACOEM Guidelines recommend topical analgesics to treat neuropathic or osteoarthritic pain. However, guidelines do not recommend the use of topical muscle relaxants as there is no evidence to support their efficacy. As such, the request for topical Cyclophene 5% is non-certified.

**Compounded Ketoprofen 20%:** Upheld

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

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

**Decision rationale:** California MTUS/ACOEM Guidelines recommend the use of topical analgesics to treat neuropathic and osteoarthritic pain. Currently, the only topical NSAID approved for use is Voltaren gel 1%; ketoprofen is not approved for topical application due to its high incidence of photocontact dermatitis. As such, guideline requirements have not been met and the request for ketoprofen 20% is non-certified.