

<b>Case Number:</b>	CM13-0053471		
<b>Date Assigned:</b>	01/15/2014	<b>Date of Injury:</b>	02/02/2011
<b>Decision Date:</b>	05/07/2014	<b>UR Denial Date:</b>	11/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2013

### 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 Orthopedic Surgery 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:

This is a 34-year-old gentleman who sustained a repetitive stress injury to the left wrist on 02/02/11. The medical records provided for review included a progress report of 08/08/13 documenting the need for continued treatment to the wrist with multiple medications including topical compounds. The records documented that the claimant was status post a first dorsal compartment release in September 2011 followed by a revision neurolysis of the radial nerve and decompression of the first dorsal compartment on 04/03/12. The report of an MRI of the left wrist dated 08/07/13 showed a positive ulnar variance and small effusion at the radio carpal and intercarpal joint, but no acute findings. Physical examination findings were not noted dating back to 07/11/13 at which time there was an examination showing 4/5 wrist strength with full sensation but mildly diminished sensation to touch along the superficial branch of the median nerve distribution with a diagnosis of de Quervain's tenosynovitis status post surgery with neuritis of the median nerve.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**120 GMS OF KETOPROFEN COMPOUND 20% IN PLO GEL:** 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:** Based on the California MTUS Chronic Pain Guidelines, the request for Ketoprofen cannot be recommended as medically necessary. According to the Chronic Pain Guidelines, topical analgesics are noted to be largely experimental in their use with few randomized clinical trials demonstrating their efficacy. Ketoprofen specifically is noted to be non-FDA approved for use in the topical setting. The information in the Chronic Pain Guidelines fails to support the medical necessity for Ketoprofen.

**120GMS OF CYCLOPHENE 5% (CYCLOBENZAPRINE HCl) IN PLO GEL:** 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 CA MTUS Chronic Pain Guidelines do not support the request for the topical compound containing cyclobenzaprine. MTUS Chronic Pain Medical Treatment Guidelines in regards to muscle relaxants, clearly indicate that there is no efficacy for the use of muscle relaxants as a topical agent. Therefore, the specific role of this topical compound would thus not be indicated as a muscle relaxant agent.

**500ML OF SYNAPRYN 10MG/1ML:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78 &93-94,111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids-Tramadol (Ultram), Page(s): 91-94.

**Decision rationale:** The CA MTUS Chronic Pain Guidelines do not recommend the continued use of Synapryn. Synapryn is a brand form of Tramadol. The clinical guidelines in regard to Tramadol do not support its use in the chronic setting beyond 16 weeks. The claimant's long term and long standing use of the agent in question would fail to necessitate its continued need at this stage in clinical course of care.

**250ML OF TABRADOL 1MG/1ML:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain), Page(s): 63.

**Decision rationale:** The CA MTUS Chronic Pain Guidelines do not support the continued role of Tabradol. Tabradol is a muscle relaxant and would have no clinical purpose at this stage in the claimant's chronic course of care. Muscle relaxants are used with caution as second line agents in the chronic pain setting. Given lack of indication of an acute exacerbation of the claimant's current clinical presentation, the continued role of muscle relaxants would not be indicated.

**250ML OF DEPRIZINE 15MG/ML:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 67-73.

**Decision rationale:** The CA MTUS Chronic Pain Guidelines do not support continuation of Deprezine. Deprezine a protective protein pump inhibitor and would only be indicated if the claimant had a significant GI risk factor in conjunction with high dose or multiple no steroidal usages. The medical records provided for review do not indicate that the claimant is currently taking a no steroidal medication. The medical records also do not identify a GI risk factor that would support the continued role of this agent. The specific request for continued role of this agent would not be indicated.

**150ML OF DICOPANOL 5MG/36:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation The Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Official Disability Guidelines Treatment in Worker's Comp, 18th Edition, 2013 Updates: pain procedure - Insomnia treatment.

**Decision rationale:** The CA MTUS and ACOEM Guidelines do not address this request. Based upon the Official Disability Guidelines the request for Dicopanol, a sedating antihistamine suggested for use for sleep deprivation would not be indicated. Official Disability Guidelines document that these medications cause a tolerance to develop within a few days of use and do not recommend their use in treatment of insomnia. More importantly, the claimant's current clinical picture does not indicate the specific diagnosis of insomnia that would support the use of sleeping aids or insomnia medications. Specific request in this case would not be supported.