MAXIMUS Federal Services

Case Number:	CM13-0064865		
Date Assigned:	01/15/2014	Date of Injury:	12/08/2011
Decision Date:	04/22/2014	UR Denial Date:	11/14/2013
Priority:	Standard	Application Received:	12/12/2013

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 Family Medicine, and is licensed to practice in Arizona. 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 patient is a 66 year old male with a date of injury on 12/8/11. The patient has been treated for ongoing knee pain, and is status post right knee arthroscopy. Diagnosis is of right knee internal derangement. Subjective complaints are of knee pain rated 9/10 that persists but medications offer temporary relief and improves sleep. Physical exam shows well-healed surgical scars, tenderness over medial joint line, pes anserinus bursa, 2+ effusion, and decreased range of motion. Medications include topical Ketoprofen, Cyclobenzaprine, oral suspension of tramadol/glucosamine, and oral suspension of Cyclobenzaprine, ranitidine, diphenhydramine, and Gabapentin. The patient denies any adverse effects from medications. There is no documentation of current or prior GI disturbances.

IMR ISSUES, DECISIONS AND RATIONALES

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

COMPOUNDED KETOPROFEN 20% IN PLO GEL 120G: Upheld

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

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

Decision rationale: The MTUS Chronic Pain Guidelines indicate that topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but with a diminishing effect over another 2-week period. The NSAID in this compound is Ketoprofen, which is not currently FDA approved for a topical application. For these reasons, this medication does not meet current use guidelines, and is therefore not medically necessary and appropriate.

. COMPOUND CYCLOPHENE 5% IN PLO GEL 120G: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines section on Cyclobenzaprine and the section on Topical Analgesics Page(s): 41-42 111-113.

Decision rationale: This topical medication contains Cyclobenzaprine. The MTUS Chronic Pain Guidelines indicate that the use of Cyclobenzaprine should be used as a short term therapy, and the effects of treatment are modest and may cause adverse effects. This patient had been using muscle relaxers chronically which are longer than the recommended course of therapy of 2-3 weeks. Furthermore, MTUS Chronic Pain Guidelines state there is no evidence for use of any muscle relaxant as a topical product. There is no evidence in the documentation that shows evidence of muscle spasm or that the patient experienced improvement with the ongoing use of Cyclobenzaprine. Due to clear guidelines suggesting Cyclobenzaprine as short term therapy and no clear benefit from adding this medication the requested prescription for Cyclobenzaprine is not medically necessary and appropriate.

SYNAPRYN 10MG/1ML ORAL SUSPENSION 500ML 1 TSP: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines section on Opioids Page(s): 74-96.

Decision rationale: This medication contains tramadol and glucosamine and other proprietary ingredients in an oral suspension. The MTUS Chronic Pain Guidelines are clear that if the medication contains one drug that is not recommended the entire product should not be recommended. Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. The MTUS Chronic Pain Guidelines has specific recommendations for the ongoing management of opioid therapy. Clear evidence should be presented about the degree of analgesia, level of activity of daily living, adverse side effects, or aberrant drug taking behavior. For this patient, there is no evidence of the need for these medications to be compounded together, or any ongoing functional improvement related to this medication. Therefore, the request for Synapryn is not medically necessary and appropriate.

TABRADOL 1MG/ML ORAL SUSPENSION 250ML 1 TSP: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines section on Cyclobenzaprine , and the section on Cyclobenzaprine Page(s): 41-42 63.

Decision rationale: This medication contains Cyclobenzaprine. The MTUS Chronic Pain Guidelines indicate that the use of Cyclobenzaprine should be used as a short term therapy, and the effects of treatment are modest and may cause adverse effects. This patient had been using muscle relaxers chronically which are longer than the recommended course of therapy of 2-3 weeks. There is no evidence in the documentation that shows evidence of muscle spasm or that the patient experienced improvement with the ongoing use of Cyclobenzaprine. Due to clear guidelines suggesting Cyclobenzaprine as short term therapy and no clear benefit from adding this medication, the requested prescription for Cyclobenzaprine is not medically necessary and appropriate.

DEPRIZINE 15MG/ML ORAL SUSPENSION 250ML 2TSP: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines section on NSAIDs GI Risk Page(s): 69.

Decision rationale: This medication is an oral suspension of ranitidine. According to the MTUS Chronic Pain Guidelines, a proton-pump inhibitor (PPI) or H2 blocker can be added to NSAID therapy if the patient is at an intermediate to high risk for adverse GI events. Guidelines identify the following as risk factors for GI events: age >65, history of peptic ulcer, GI bleeding or perforation, use of ASA, corticosteroids, anticoagulant use, or high dose NSAIDS. There is no documentation identified that would stratify this patient in an intermediate or high risk GI category. The MTUS Chronic Pain Guidelines specifically states that treatment of dyspepsia secondary to NSAID therapy should include stopping the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI. Since the patient has no history of peptic ulcers, GI bleeding, or documentation of dyspepsia, and is not using NSAIDs, the requested prescription for Deprizine is not medically necessary and appropriate.

DICOPANOL (DIPHENYDRAMINE) 5MG/ML ORAL SUSPENSION 150ML 2ML HS: 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, Pain, section on Insomnia Treatment

Decision rationale: This medication is an oral suspension of diphenhydramine. The request is for this medication to be used at night for treatment of insomnia. The ODG states that pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. The ODG suggests that sedating antihistamines are a class of drug that can be used for insomnia. The ODG states that sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine), and tolerance seems to develop within a few days. The submitted documentation does not show evidence of evaluation of insomnia or the extent or type of insomnia of which the patient is experiencing. Therefore, the request for Dicopanol is not medically necessary and appropriate.

FANATREX (GABAPENTIN) 25MG/ML ORAL SUSPENSION 420ML 1 TSP LID: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines section on AEDs Page(s): 16.

Decision rationale: The MTUS Chronic Pain Guidelines indicate that Gabapentin is an anti-seizure medication that is recommended for neuropathic pain treatment. MTUS Guidelines also adds that following initiation of treatment there should be documentation of at least 30% pain relief and functional improvement. The continued use of an anti-epileptic drug (AED) for neuropathic pain depends on these improved outcomes. The medical records do not indicate any pain relief or functional improvement specific to this medication. The submitted documentation also does not demonstrate pain of neuropathic origin. Therefore, the medical necessity of fanatrex is not established.