

Case Number:	CM13-0071003		
Date Assigned:	01/08/2014	Date of Injury:	08/23/2012
Decision Date:	04/30/2014	UR Denial Date:	11/21/2013
Priority:	Standard	Application Received:	12/26/2013

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 Physical Medicine & Rehabilitation 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:

The patient is a 49-year-old female who reported an injury on 08/23/2012. The patient was reportedly injured when a door handle collided with her right forearm. The patient is currently diagnosed with cervical spine multilevel herniated nucleus pulposus, cervical spine multilevel degenerative disc disease, rule out cervical radiculopathy, left shoulder tendinitis, right elbow lateral epicondylitis, right forearm sprain, right wrist sprain, rule out right wrist carpal tunnel syndrome, mood disorder, sleep disorder, and anxiety disorder. The patient was seen on 10/18/2013. The patient reported persistent pain in the cervical spine and bilateral upper extremities. Physical examination revealed tenderness in the sub occipital region, decreased cervical range of motion, tenderness at the rotator cuff tendon attachment site, decreased left shoulder range of motion, tenderness at the flexor and extensor muscle compartments of the right elbow and forearm, decreased right elbow range of motion, tenderness at the carpal tunnel, decreased range of motion of the right wrist, positive Tinel's and Finkelstein's testing, and intact sensation. Treatment recommendations included physical therapy and continuation of current medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

120GM OF COMPOUNDED CYCLOPHENE 5% IN PLO GEL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

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

Decision rationale: According to the documentation provided, the patient has utilized Cyclophene, which contains cyclobenzaprine and other proprietary ingredients since 04/2013. California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. Muscle relaxants are not recommended, as there is no evidence for the use of a muscle relaxant as a topical product. There is also no quantity listed in the request. Therefore, the request is not medically appropriate. As such, the request is non-certified.

120GM OF COMPOUNDED KETOPROFEN 20% IN PLO GEL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

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

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. The only FDA approved topical NSAID is diclofenac. There is also no quantity listed in the request. Therefore, the request is not medically appropriate. As such, the request is non-certified

8 SESSIONS OF PHYSICAL THERAPY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

Decision rationale: California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. This is a non-specific request and does not include the body part or the frequency of treatment. Therefore, the request is non-certified.

250ML OF TABRADOL (CYCLOBENZAPRINE HYDROCHLORIDE) 1MG/ML ORAL SUSPENSION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short term treatment of acute exacerbations. Cyclobenzaprine should not be used for longer than 2 weeks to 3 weeks. There was no evidence of palpable muscle spasm or muscle tension upon physical examination. The patient has utilized Tabradol since at least 04/2013, without any evidence of objective improvement. There is also no indication that this patient cannot safely swallow pills or capsules. Based on the clinical information received, the request is non-certified.

500ML OF SYNAPRYN (TRAMADOL) 10/MG/ML ORAL SUSPENSION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 88, 89, 93.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the patient has utilized Synapryn since at least 04/2013. There is no documentation of a satisfactory response to treatment. There is also no indication that this patient cannot safely swallow pills or capsules. Therefore, the request is non-certified.

420 ML OF FANATREX (GABAPENTIN) 25MG/ML ORAL SUSPENSION: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-18.

Decision rationale: California MTUS Guidelines state anti-epilepsy drugs are recommended for neuropathic pain. As per the documentation submitted, the patient has utilized Fanatrex since at least 04/2013. Despite ongoing use, the patient continues to report high levels of pain. Satisfactory response to treatment has not been indicated. There is also no indication that this patient is unable to swallow pills or capsules. Based on the clinical information received, the request is non-certified.

250ML OF DEPRIZINE (RANITIDINE) 15MG/ML ORAL SUSPENSION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

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

Decision rationale: California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a non-selective NSAID. There is no evidence of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the patient does not meet criteria for the requested medication. There is also no indication that this patient cannot safely swallow pills or capsules. Based on the clinical information received, the request is non-certified.

**150ML OF DICOPANOL (DIPHENHYDRAMINE HYDROCHLORIDE) 5MG/ML
ORAL SUSPENSION:** Upheld

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

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 Chapter, and Insomnia Treatment

Decision rationale: Official Disability Guidelines state diphenhydramine is a sedating antihistamine often utilized as an over the counter medication for insomnia treatment. As per the documentation submitted, the patient has utilized Dicopanol since at least 04/2013. Despite ongoing use, the patient continues to report persistent insomnia. There is also no indication that this patient cannot safely swallow pills or capsules. Based on the clinical information received, the request is non-certified.