

Case Number:	CM13-0071866		
Date Assigned:	01/08/2014	Date of Injury:	04/25/2003
Decision Date:	06/05/2014	UR Denial Date:	12/13/2013
Priority:	Standard	Application Received:	12/30/2013

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 and Rehabilitation and is licensed to practice in Illinois. 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 injured worker is a 56 year old female who reported a repetitive motion neck injury on 04/25/2003. Within the clinical note dated 12/10/2013 the injured worker reported pain in the left shoulder rated 3/10 with medication and rated 10/10 without medication. The physical exam reported no change in functional status with moderate to severe limitation. Additionally, there was no change in the range of motion in the cervical spine, lumbar spine, muscle testing, and shoulder in all aspects when compared to the clinical exam on 10/28/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

COMPOUND KETOPROFEN 20% GEL 120 GM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section, Page(s): 111-112.

Decision rationale: The request for compound ketoprofen 20% gel is non-certified. The CA MTUS guidelines recommend topical NSAIDs for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Within the documentation it is unclear how long the injured worker has utilized this gel and

whether it exceeds the recommended time frame. Additionally, the indicated usage from the clinical note suggests the usage is for the shoulder and is contraindicated by the guidelines. Hence, the request is not medically necessary or appropriate.

COMPOUND CYCLOPHENE 5% GEL 120GM: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment.

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

Decision rationale: The request for compound cyclophene 5% is non-certified. The CA MTUS does not recommend muscle relaxants because there is no evidence for use of any other muscle relaxant as a topical product. Hence, the request is not medically necessary or appropriate.

DICOPANOL 5MG SUSPENSION 150 ML: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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), Mental Illness & Stress Chapter, Insomnia Treatment Section.

Decision rationale: The request for Dicopanol 5mg suspension 150ml is non-certified. The primary component of Dicopanol is diphenhydramine. The Official Disability Guidelines (ODG) cite that tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. This RCT determined that diphenhydramine has been shown to build tolerance against its sedation effectiveness very quickly, with placebo-like results after a third day of use. The injured worker has unclear documentation for the duration they had been using this medication and the current request exceeds the guidelines recommend duration. Hence, the request is not medically necessary or appropriate.

DEPRIZINE 15MG 250 ML: Upheld

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

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

Decision rationale: The request for Deprizine 15mg 250ml is non-certified. The primary component of Deprizine is ranitidine. The CA MTUS guidelines recommend the use of proton pump inhibitors if there is a history of gastrointestinal bleeding or perforations, a prescribed high dose of NSAIDs and a history of peptic ulcers. Within the clinical notes reviewed there was a

lack of documentation of any medication the injured worker was taking; hence, it is unable to be determined if any medication would warrant the use of a proton pump inhibitor. The injured worker also fails to fit the criteria of any gastrointestinal bleeding or perforation. Thus, the request is not medically necessary or appropriate.

FANATREX 25MG SUSPENSION 150 ML: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 49.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Section, Page(s): 49.

Decision rationale: The request for Fanatrex 25mg suspension 150ml is non-certified. The CA MTUS recommends gabapentin as a first-line medication for neurologic pain. It was unclear in the documentation why the injured worker was unable to swallow the pill form and the medical necessity for an oral suspension. In addition, there is a lack of documentation of neuropathic pain. Hence, the request is not medically necessary or appropriate.

SYNAPRYN 10MG SUSPENSION 500 ML: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 50.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Section, Page(s): 78.

Decision rationale: The request for Synapryn 10mg suspension 500ml is non-certified. The active ingredient of Synapryn is tramadol hydrochloride. The CA MTUS guidelines recognizes four domains that have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. There is a lack of documentation that the injured worker has had urine drug screens to validate proper medication adherence in the submitted paperwork. In addition, within the clinical notes the injured worker has reported high pain ratings and the limited pain assessments did not indicate whether the pain rating were done with or without medication. Lastly, the injured worker did not show any objective signs of functional improvement while on the medication. Hence, the request is not medically necessary or appropriate.

TABRADOL 1MG SUSPENSION 250 ML: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxant Section, Page(s): 64.

Decision rationale: The request for Tabradol 1mg suspension 250ml is non-certified. The CA MTUS recommends Cyclobenzaprine for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. It is unclear in the documentation how long the injured worker has utilized the medication; however the current request exceeds the recommended guidelines. Moreover, there was a lack of documentation why the injured worker could not utilize the pill form of Cyclobenzaprine. Hence, the request is not medically necessary or appropriate.