

Case Number:	CM14-0014862		
Date Assigned:	02/28/2014	Date of Injury:	02/15/2011
Decision Date:	07/10/2014	UR Denial Date:	01/10/2014
Priority:	Standard	Application Received:	02/05/2014

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, has a subspecialty in Pain Medicine 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 38-year-old male who was injured on 02/15/2011. Mechanism of injury is unknown. Prior treatment history has included the patient having undergone manipulation under anesthesia of the right shoulder and arthroscopic subacromial decompression, partial anterior acromionectomy with bursectomy on 04/12/2013. As of 11/04/2013, his medications consist of Hydrocodone, Ranitidine, Naproxen, and depression medication. Diagnostic studies reviewed include an EMG/NCV on 04/26/2012 consistent with right carpal tunnel syndrome. There is no urine drug screen submitted for review. The progress report dated 12/07/2013 documented the patient with complaints of ongoing problems with the right upper extremity including numbness, tingling, and pain. The patient continues to have neck pain. Objective findings on exam reveal range of motion of the left shoulder flexion 110 degrees, abduction 110 degrees. Phalen's test is positive. There is cervical spine tenderness. The diagnosis included status post right shoulder decompression with residual adhesive capsulitis, cervical strain, and right carpal tunnel syndrome. Recommended treatment plan was for carpal tunnel release, patient was temporarily totally disabled from work, medications were refilled, and the patient was to return to the office in six weeks. The UR report dated 01/10/2014 denied the request for Synapryn 10mg/1ml/500 as there is no evidence of the traditional oral formulation of tramadol in oral tablet form has been tried and failed or is not tolerated to support the necessity for this formulation. The request for Deprizine 5 mg/250ml is denied because there is no evidence that these clinical issues are present. The medical necessity of the request has not been established. The requests for Dicopanorol 5mg/150ml and Fanatrex 25 mg/420ml have been denied because the medical necessity of the request has not been established. The request for Tabradol 1 mg/250ml is not supported as this muscle relaxant is generally indicated for acute or subacute spasm and not for

chronic pain therefore is denied. The requests for Ketoprofen 20% and Cyclobenzaprine 5% Gel 120 gm are denied because the medical necessity has not been established.

IMR ISSUES, DECISIONS AND RATIONALES

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

SYNAPRYN 10MG/ML, 500ML: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93-94, 50.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol, Opioids Page(s): 113, 74-96.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. The medical records document the patient was diagnosed with status post right shoulder decompression with residual adhesive capsulitis, cervical strain, and right carpal tunnel syndrome. There is no documented failure trial of first line medication such as antiepileptic and antidepressant medication. In addition, the guidelines do not support using Tramadol in oral suspension form. Therefore, the request is not medically necessary.

TABRADOL 1ML/ML, 250ML: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93-34, 50.

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

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine is recommended as an option, using a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system (CNS) depressant. The medical records document the patient was diagnosed with status post right shoulder decompression with residual adhesive capsulitis, cervical strain, and right carpal tunnel syndrome. The patient is currently on Norco. There is no documented low back pain. Therefore, the request is not medically necessary.

DEPRIZINE 5MG/ML, 250ML: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93-34, 50.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, H2-receptor antagonist is recommended when there is concurrent use of SSRIs and NSAIDs as it is associated with moderate excess relative risk of serious upper GI events when compared to NSAIDs alone. The medical records document the patient was diagnosed with status post right shoulder decompression with residual adhesive capsulitis, cervical strain, and right carpal tunnel syndrome. There is no documented SSRIs as one of patient's medication and in the absence of GI events, the request is not medically necessary.

DICOPANOL 5MG/ML, 150ML: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93-94, 50.

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, Insomnia treatment.

Decision rationale: According to the ODG, Sedating antihistamines have been suggested for sleep aids. NCQA has included diphenhydramine in the HEDIS recommended list of high-risk medications to avoid in the elderly. The medical records document the patient was diagnosed with status post right shoulder decompression with residual adhesive capsulitis, cervical strain, and right carpal tunnel syndrome. There is no documented insomnia and the patient is on other antidepressant medication. Based upon review of the records provided, the necessity for this medication has not been established. Therefore, the request is not medically necessary.

FANATREX 25MG/ML, 420ML: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93-94, 50.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 18-19, 49.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, Gabapentin is recommended for treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The medical records document the patient was diagnosed with status post right shoulder decompression with residual adhesive capsulitis, cervical strain, and right carpal tunnel syndrome. There is no documented diabetic neuropathy or clear neuropathic pain and the patient is on other antidepressant medications. Therefore, the request is not medically necessary.

KETOPROFEN 120GM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112-113.

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

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Ketoprofen 120 gm is a topical form, this agent is not currently FDA approved for a topical application. It has an extremely high incidence of photo contact dermatitis. Therefore, the request is not medically necessary.

CYCLOBENZAPRINE 120GM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112-113.

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

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Cyclobenzaprine 120 gm is a topical form; this agent is not recommended, as there is no evidence for use of any other muscle relaxant as a topical product. Therefore, the request is not medically necessary.