

Case Number:	CM14-0147592		
Date Assigned:	09/15/2014	Date of Injury:	06/07/2013
Decision Date:	12/24/2014	UR Denial Date:	08/19/2014
Priority:	Standard	Application Received:	09/11/2014

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 Internal Medicine and is licensed to practice in New York. 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 37 year old male that sustained work related cumulative type injuries involving his mid and low back dating 04/01/2013 to 02/20/2014, as well as a specific type injury to his right shoulder and elbow on 06/07/2013 while working as a food runner. According to a primary treating physician's report dated 07/16/2014, the injured worker presented with complaints of sharp, stabbing right shoulder, right elbow and low back pain, along with dull, achy, and sometimes sharp mid back pain. Diagnoses included right shoulder sprain/strain, tendonitis, and AC (acromioclavicular) arthrosis; right elbow lateral epicondylitis; thoracic spine pain, sprain/strain, and herniated nucleus pulposus; low back pain; lumbar spine sprain/strain and radiculopathy; and lumbar disc displacement herniated nucleus pulposus. According to received medical records, treatments have consisted of physical therapy, medications and awaiting a lumbosacral orthosis brace. No diagnostic testing was noted in medical records, but the treating physician has requested an MRI of the lumbar spine. Work status is not mentioned in received medical records or in the Utilization Review report. On 08/19/2014, Utilization Review denied the request for Ketoprofen 20% Cream 165 Grams, Synapryn 10mg/ 1 ml Oral Suspension 500ml, Deprizine 15mg/ml Oral Suspension 250ml, Dicopanol (Diphenhydramine) 5mg/ml Oral Suspension 150ml, Cyclobenzaprine 5% Cream 100 Grams, Tabradol 1mg/ml Oral Suspension 250ml, and Fanatrex (gabapentin) 25mg/ml 420ml citing California MTUS Guidelines. The Utilization Review physician stated that none of the guideline criteria have been met and only partially met on the Synapryn medication. Therefore, the Utilization Review decision was appealed for an Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 20% Cream, 165 grams: Upheld

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

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

Decision rationale: There is no documentation provided necessitating use of the requested topical medication. Per California MTUS Guidelines topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, Capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, alpha-adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, γ agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor) Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case Ketoprofen is not FDA approved for a topical application. Medical necessity for the requested item is not established. The requested treatment is not medically necessary.

Synapryn 10mg/1ml Oral Suspension, 500ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93, 94-96.

Decision rationale: The review of the medical documentation indicates that the requested medication, Ultram is not medically necessary and indicated for the treatment of the claimant's chronic pain condition. Per California MTUS, Ultram (Tramadol) is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. Per the medical documentation there has been no documentation of the medication's pain relief effectiveness and no clear documentation that he has responded to ongoing opioid therapy. According to the California MTUS Guidelines there has to be certain criteria followed including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred with this patient. The patient may require a multidisciplinary evaluation to determine

the best approach to treatment of his chronic pain syndrome. Medical necessity for the requested item has not been established. The requested treatment is not medically necessary.

Deprizine 15mg/ml Oral Suspension, 250ml: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Medscape Internal Medicine 2013: Ranitidine indications

Decision rationale: There was no specific indication for Ranitidine use. The medication is used to treat ulcers, gastroesophageal reflux disease, esophagitis, Hypersecretory conditions (Zollinger-Ellison syndrome), and stress ulcer prophylaxis. There was no clear detail provided in the available documentation as to why the medication is required, and there is no documentation of the claimant having any particular objective GI abnormalities. The medical necessity for the requested item is not established. The requested item is not medically necessary.

Dicopanol (Diphenhydramine) 5mg/ml Oral Suspension, 150ml: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.nlm.nih.gov

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Medscape Internal medicine 2013: Diphenhydramine

Decision rationale: Diphenhydramine is used to relieve red, irritated, itchy, watery eyes; sneezing; and runny nose caused by hay fever, allergies, or the common cold. Diphenhydramine is also used to relieve cough caused by minor throat or airway irritation. Diphenhydramine is also used to prevent and treat motion sickness, and to treat insomnia (difficulty falling asleep or staying asleep). Diphenhydramine is also used to control abnormal movements in people who have early stage Parkinsonian syndrome (a disorder of the nervous system that causes difficulties with movement, muscle control, and balance) or who are experiencing movement problems as a side effect of a medication. Diphenhydramine will relieve the symptoms of these conditions but will not treat the cause of the symptoms or speed recovery. Diphenhydramine should not be used to cause sleepiness in children. Diphenhydramine is in a class of medications called antihistamines. It works by blocking the action of histamine, a substance in the body that causes allergic symptoms. There is no indication for the use of this medication for treatment of the claimant's chronic pain condition. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

Cyclobenzaprine 5% Cream, 100 grams: Upheld

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

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

Decision rationale: There is no documentation provided necessitating use of the requested topical medication. Per California MTUS Guidelines topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, alpha-adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, γ agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor) Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case Cyclobenzaprine is not FDA approved for a topical application. Medical necessity for the requested item is not established. The requested treatment is not medically necessary.

Tabradol 1mg/ml Oral Suspension, 250ml: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: There is no documentation provided necessitating use of the requested topical medication. Per California MTUS Guidelines topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, alpha-adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, γ agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor) Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case Cyclobenzaprine is not FDA approved for a topical application. Medical necessity for the requested item is not established. The requested treatment is not medically necessary.

Fanatrex (gabapentin) 25mg/ml, 420ml: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13.

Decision rationale: The recommended medication, Gabapentin is medically necessary for the treatment of the patient's condition. Per the documentation he has neuropathic pain as part of his chronic pain condition. The medication is part of his medical regimen and per California MTUS Guidelines 2009 antiepilepsy medications are a first line treatment for neuropathic pain. A recommended trial period for an adequate trial of gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. The patient has been prescribed the medication and the medical record documents a positive response. Medical necessity has been documented and the requested treatment is medically necessary for treatment of the patient's chronic pain condition.