

Case Number:	CM14-0167674		
Date Assigned:	10/15/2014	Date of Injury:	04/21/2013
Decision Date:	12/04/2014	UR Denial Date:	09/11/2014
Priority:	Standard	Application Received:	10/10/2014

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 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 injured worker is a 45 year old female who reported injury on 04/21/2013. The mechanism of injury was while making a bed and expanding sheets in performance of her job duties. Her diagnoses included cervical disc disease, right carpal tunnel syndrome and right shoulder tendinitis/bursitis and impingement syndrome. Her past treatments included cortisone injection, physical therapy, chiropractic treatment, and medications. Diagnostic studies included x-rays and an MRI of the right shoulder on 04/22/2013, an MRI of the cervical spine on 07/03/2014, and an EMG/NCV of the upper extremities on 07/24/2014. The injured worker's surgical history included a right shoulder subacromial decompression on 07/24/2014. On 08/12/2014 the injured worker reported burning right shoulder pain radiating down the arm to the hand and fingers, accompanied by spasms. She rated her pain moderate to severe at 7/10 and described the pain as constant. Her pain was intensified with pulling, lifting, or above the shoulder work. The physical examination noted decreased range of motion to the right shoulder, with sensitivity at the delto-pectoral groove and insertion of the supraspinatus muscle. On 09/04/2014 she complained of cervical spine pain rated 5/10 described as constant, sharp, burning and throbbing with radiation into the right shoulder and down to the fingers with numbness, weakness and a tingling sensation. Upon assessment the injured worker was noted to have decreased range of motion of the cervical spine and right shoulder. It was indicated the injured worker was not taking medications for her symptoms. The treatment plan and physician's rationale for the request were not provided within the documentation. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 20 Percent Cream 165 Grams: Upheld

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

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

Decision rationale: The California MTUS guidelines note topical NSAIDs, such as Ketoprofen, are recommended for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment 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 and use with neuropathic pain is not recommended as there is no evidence to support use. The guidelines note Ketoprofen is not currently FDA approved for a topical application as it has an extremely high incidence of photocontact dermatitis. There is a lack of documentation indicating the injured worker has osteoarthritis or tendinitis to a joint amenable to topical treatment. There is a lack of documentation demonstrating why the injured worker would require topical medication as opposed to oral medications. Additionally, the request does not indicate the frequency at which the medication is prescribed as well as the site at which it is to be applied in order to determine the necessity of the medication. As such, the request for Ketoprofen 20 Percent Cream 165 Grams is not medically necessary.

Cyclobenzaprine 5 Percent Cream 100 Grams: Upheld

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

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

Decision rationale: The California MTUS guidelines note topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. The guidelines also note there is no evidence to support the use of muscle relaxants, such as cyclobenzaprine, for topical application. There is a lack of documentation demonstrating why the injured worker would require topical medication as opposed to oral medications. The guidelines do not recommend the use of muscle relaxants for topical application; therefore, as the guidelines note any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended, the medication would not be indicated. As such, the request for Cyclobenzaprine 5 Percent Cream 100 Grams is not medically necessary.

Deprizine 15 MG/ML X 250 ML; Dicopanol 5 MG/ML X 150 ML: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Therapy Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Insomnia treatment & Compound drugs

Decision rationale: Deprizine is ranitidine hydrochloride compounded into an oral suspension and Dicopanол is diphenhydramine hydrochloride compounded into an oral suspension. The California MTUS guidelines recommend the use of an H2 antagonist (Deprizine) in the treatment of dyspepsia secondary to NSAID therapy. The Official Disability Guidelines state sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine). Tolerance seems to develop within a few days and next-day sedation has been noted as well as impaired psychomotor and cognitive function. The Official Disability Guidelines note compounded medications are not recommended as a first line therapy. The guidelines note a compounded medication must include at least one drug substance (or active ingredient) that is the sole active ingredient in an FDA-approved prescription drug, not including over the counter drugs, include only bulk ingredients that are components of FDA-approved drugs that have been made in an FDA-registered facility and have an NDC code, and should include only drug substances that have been supported as safe and effective for the prescribed indication by the FDA-approval process and/or by adequate medical and scientific evidence in the medical literature. Compound medications should not contain a drug which has been withdrawn or removed from the market for safety reasons and these medications should not be a copy of a commercially available FDA-approved drug product. There is a lack of documentation demonstrating why the injured worker would require an oral suspension as opposed to traditional oral medication administration routes. There is a lack of documentation demonstrating that the injured worker has significant gastrointestinal symptoms for which medication would be needed. There is no indication that the injured worker has significant insomnia for which the use of a sedating antihistamine would be indicated. The requesting physician's rationale for the request is not indicated within the provided documentation. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. As such, the request for Deprizine 15 mg/ml x 250 ml; Dicopanол 5 mg/ml x 150 ml is not medically necessary.