

Case Number:	CM14-0059959		
Date Assigned:	08/08/2014	Date of Injury:	05/13/2010
Decision Date:	09/11/2014	UR Denial Date:	04/10/2014
Priority:	Standard	Application Received:	04/30/2014

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, has a subspecialty in Rheumatology and is licensed to practice in Maryland. 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 patient is a 52 year old female patient with date of injury 5/3/2010. The mechanism of injury is stated as hurting her back while lifting a patient. The patient has complained of lower back pain, bilateral wrist and hand pain as well as bilateral foot pain since the date of injury. She has been treated with medication, chiropractic therapy and physical therapy since the date of injury. MRI of the lumbar spine dated 12/2013 revealed mild to moderate neuroforaminal narrowing secondary to disc bulging and facet joint hypertrophy at L4-5 and disc disease at L5-S1. MRI of the right foot performed in 12/2013 revealed no significant findings. Objective: tenderness to palpation over the bilateral hands, positive Phalen's test bilaterally; lumbar spine paraspinous muscle tenderness with palpation, tenderness to palpation of the lumbosacral junction, decreased and painful range of motion of the lumbar spine; decreased range of motion of the bilateral ankles; cervical spine decreased and painful range of motion, decreased range of motion of the right shoulder. Diagnoses: wrist sprain, lumbar spine disc disease, spondylolisthesis of the lumbar spine, neck sprain, right shoulder impingement. Treatment plan and request: Ketoprofen gel, Cyclophene gel, Synapryn, Tabradol, Deprizine, Dicopanol, Fanatrex.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketprofen 20%, gel 120gm: 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 Topical analgesics Page(s): 111.

Decision rationale: This 52 year old female patient has complained of lower back pain, bilateral wrist and hand pain as well as bilateral foot pain since date of injury 5/3/2010. She has been treated with medication, chiropractic therapy and physical therapy since the date of injury. The current request is for Ketoprofen gel. Per the MTUS guidelines cited above, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anticonvulsants and antidepressants have failed. There is no such documentation in the available medical records. On the basis of the MTUS guidelines cited above, the Ketoprofen gel is not indicated as medically necessary.

Cyclophene 5% gel 120gm: 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 Topical Analgesics Page(s): 111.

Decision rationale: This 52 year old female patient has complained of lower back pain, bilateral wrist and hand pain as well as bilateral foot pain since date of injury 5/3/2010. She has been treated with medication, chiropractic therapy and physical therapy since the date of injury. The current request is for Cyclophene gel. Per the MTUS guidelines cited above, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anticonvulsants and antidepressants have failed. There is no such documentation in the available medical records. On the basis of the MTUS guidelines cited above, Cyclophene gel is not indicated as medically necessary.

Synapryn 10mg/1ml: 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 Opioids, criteria for use Page(s): 76-85, 88-89.

Decision rationale: This 52 year old female patient has complained of lower back pain, bilateral wrist and hand pain as well as bilateral foot pain since date of injury 5/3/2010. She has been treated with medication, chiropractic therapy and physical therapy since the date of injury. The current request is for Synapryn. No treating physician reports adequately assess the patient with

respect to function, specific benefit, return to work, signs of abuse or treatment alternatives other than opioids. There is no evidence that the treating physician is prescribing opioids according to the MTUS section cited above which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, opioid contract and documentation of failure of prior non-opioid therapy. Additionally, there is no documented provider rationale regarding the necessity of use of a compounded medication. On the basis of this lack of documentation and failure to adhere to the MTUS guidelines, Synapryn is not indicated as medically necessary.

Tabradol 1mg/ml 250ml: Upheld

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

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

Decision rationale: This 52 year old female patient has complained of lower back pain, bilateral wrist and hand pain as well as bilateral foot pain since date of injury 5/3/2010. She has been treated with medication, chiropractic therapy and physical therapy since the date of injury. The current request is for Tabradol, an oral suspension of cyclobenzaprine. Per MTUS guidelines, treatment with cyclobenzaprine should be reserved as a second line agent only and should be used for a short course (2 weeks) only, and the addition of cyclobenzaprine to other agents is not recommended. On the basis of the cited MTUS guidelines, Tabradol is not indicated as medically necessary in this patient.

Deprizine 15mg/ml 250ml: Upheld

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

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: www.drugs.com/pro/deprizine.

Decision rationale: This 52 year old female patient has complained of lower back pain, bilateral wrist and hand pain as well as bilateral foot pain since date of injury 5/3/2010. She has been treated with medication, chiropractic therapy and physical therapy since the date of injury. The current request is for Deprizine. There is no specific MTUS guideline regarding Deprizine. Per the reference cited above under Other Medical Treatment Guideline, Deprizine is an oral suspension of ranitidine and used to treat symptoms of heartburn and gastroesophageal reflux related disease. There is no documentation in the available medical records of gastroesophageal symptomatology nor is there a medical rationale regarding the necessity of delivery of the medication in an oral suspension. On the basis of the above cited medical treatment guideline and the available provider documentation, Deprizine is not indicated as medically necessary.

Dicopanol 5mg/ml 150ml: Upheld

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

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: www.drugs.com/pro/dicoproanol.

Decision rationale: This 52 year old female patient has complained of lower back pain, bilateral wrist and hand pain as well as bilateral foot pain since date of injury 5/3/2010. She has been treated with medication, chiropractic therapy and physical therapy since the date of injury. The current request is for Dicopanol. There is no specific MTUS guideline regarding Dicopanol. Per the reference cited above under Other Medical Treatment Guideline, Dicopanol is an antihistamine suspension (diphenhydramine) used to treat allergic rhinitis and motion sickness and may also be used to induce sleep. There is no specific indication or recommendation per evidenced based guidelines for use of this medication in chronic musculoskeletal pain. There are no diagnoses listed in the available medical records which support the use of this medication and no documentation regarding the specific need for a suspension formulation. On the basis of current evidenced based medical guidelines and the available documentation, Dicopanol is not indicated as medically necessary in this patient.

Fanatrex 25mg/ml 420ml: 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 Anti-epileptic drugs, page 49 Page(s): 49.

Decision rationale: This 52 year old female patient has complained of lower back pain, bilateral wrist and hand pain as well as bilateral foot pain since date of injury 5/3/2010. She has been treated with medication, chiropractic therapy and physical therapy since the date of injury. The current request is for Fanatrex. Per the MTUS guideline cited above, gabapentin is an anti-epileptic agent recommended to treat diabetic painful neuropathy and post herpetic neuropathy. There is no documentation in the available medical records that supports the presence of any of these medical conditions. On the basis of this lack of documentation, Fanatrex is not indicated as medically necessary.