

<b>Case Number:</b>	CM14-0068276		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	02/13/2014
<b>Decision Date:</b>	09/19/2014	<b>UR Denial Date:</b>	05/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/13/2014

### 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 27-year-old female who reported an injury on 02/13/2014 due to repetitive trauma while performing normal job duties. The injured worker reportedly sustained an injury to her neck, thoracic spine, lumbar spine, and bilateral shoulders. The injured worker's treatment history included medications, physical therapy, and acupuncture. The injured worker was evaluated on 06/03/2014. It was documented that the injured worker had neck pain complaints rated at a 6/10, bilateral shoulder pain complaints rated at a 6p to 8/10, bilateral elbow pain complaints rated at a 6/10 to 8/10, and wrist and hand and thumb pain complaints rated at a 6/10 to 8/10. Physical findings included tenderness to palpation of the occipitus, trapezius, levator scapula muscles, and splenius and scalene muscles with full range of motion. The injured worker had tenderness to palpation of the shoulder musculature and acromioclavicular joint with full range of motion. The injured worker had tenderness to palpation along the medial epicondyles with a positive Tinel's and Cozen's sign and full range of motion. An evaluation of the injured worker's bilateral wrists, hands, and thumbs documented thenar atrophy and positive tenderness to her left carpal tunnel with decreased muscle strength and decreased sensation to light touch in the ulnar and median nerve distribution with 4/5 motor strength. The injured worker's diagnoses included cervical spine sprain/strain, radiculopathy of the cervical region, bilateral shoulder sprain/strain, pain in bilateral elbows, bilateral elbow medial epicondylitis, bilateral elbow cubital tunnel syndrome, bilateral wrist carpal tunnel syndrome, pain in hand and fingers, and trigger thumb bilaterally. The injured worker's medications included Fanatrex, Synapryn, Tabradol, cyclobenzaprine, and ketoprofen cream. The injured worker's treatment plan included a continuation of medications, Terocin patches, and chiropractic and acupuncture care. A Request for Authorization form was submitted on 06/03/2014.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Compounded Ketoprofen 20% Poloxamer-Lecithin Organogel (PLO) Gel, 120grams, QTY: 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 112.

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

**Decision rationale:** The request for compounded ketoprofen 20%, poloxamer-lecithin organogel (PLO) gel 120 gm quantity of 1 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not support the use of ketoprofen as a topical analgesic as it is not FDA-approved to treat neuropathic pain. The clinical documentation does indicate that the injured worker has been using this medication to assist with pain relief. However, there was no justification provided to extend treatment beyond guidelines. As this is not an FDA-approved medication, continued use would not be supported. Furthermore, the request as it is submitted does not provide an applicable body part. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested compounded ketoprofen 20% poloxamer-lecithin organogel (PLO) gel 120 gm quantity of 1 is not medically necessary or appropriate.

**Compounded Cyclophene 5% Poloxamer-Lecithin Organogel (PLO) Gel, 120grams QTY: 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Compound Medication Page(s): 110-111; 113.

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

**Decision rationale:** The requested compounded cyclophene 5% poloxamer-lecithin organogel (PLO) gel 120 gm quantity 1 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not support the use of cyclobenzaprine as a topical analgesic as there is little scientific evidence to support the efficacy and safety of this medication in a topical formulation. The clinical documentation submitted for review did not provide any justification to extend treatment beyond guideline recommendations. Therefore, ongoing use of this medication would not be supported. As such, the requested cyclobenzaprine (cyclophene?) 5% poloxamer-lecithin organogel PLO gel 120 gm quantity 1 is not medically necessary or appropriate. Furthermore, the request as it is submitted does not clearly identify an applicable body part. In the absence of this information, the appropriateness of the request itself cannot be determined.

**Synapryn 10mg/10ml, 500ml, QTY: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Synthetic Opioid (Tramadol) Page(s): 94-95. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist and Hand.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, and Glucosamine Page(s): 78 and 50.

**Decision rationale:** The requested Synapryn 10 mg/10 ml 500 ml quantity of 1 is not medically necessary or appropriate. The requested medication has a compounded medication that contains glucosamine and tramadol. The California Medical Treatment Utilization Schedule does recommend glucosamine in the management of osteoarthritic pain. However, the California Medical Treatment Utilization Schedule recommends the ongoing use of any medication used for chronic pain be supported by documented functional benefit and evidence of pain relief. The clinical documentation does not provide any evidence of pain relief or functional benefit resulting from this medication. Additionally, the California Medical Treatment Utilization Schedule recommends the ongoing use of opioids be supported by documented functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence to support efficacy of treatment or that the injured worker is monitored for aberrant behavior. Therefore, ongoing use of this medication would not be supported. Additionally, there was no documentation to support the need for a liquid formulation over a standard oral formulation of this medication. As such, the requested Synapryn 10 mg/10 ml 500 ml quantity of 1 is not medically necessary or appropriate.

**Tabradol 1mg/mg, 250ml, QTY: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non Sedating Muscle Relaxant Page(s): 63.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

**Decision rationale:** The requested Tabradol is not medically necessary or appropriate. The requested medication contains a liquid form of cyclobenzaprine. The California Medical Treatment Utilization Schedule does not recommend the long-term use of cyclobenzaprine as it is primarily recommended for short durations of treatment not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. The clinical documentation submitted for review does indicate that the injured worker has been on this medication for an extended duration. Therefore, continued use would not be supported. Additionally, there was no justification provided of why a liquid formulation of this medication was needed over a more standard oral formulation. As such, the requested Tabradol 1 mg/mg 200 ml quantity of 1 is not medically necessary or appropriate.

**Deprizine 15mg/ml, 250ml, QTY:1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's Page(s): 68.

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

**Decision rationale:** The requested deprizine is a liquid formulation of ranitidine. The California Medical Treatment Utilization Schedule recommends gastrointestinal protectants for injured workers who are at risk for developing gastrointestinal events related to medication usage. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's gastrointestinal system to support that they are at continued risk for developing gastrointestinal events related to medication usage. Therefore, ongoing use of this medication would not be supported. Furthermore, there was no justification provided within the request to support the need for a liquid formulation over a more standard oral formulation of this medication. As such, the requested deprizine 15 mg/ml 250 ml quantity of 1 is not medically necessary or appropriate.

**Dicopanol 5mg/ml, 150ml, QTY: 1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental, Insomnia Treatment.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Insomnia treatments.

**Decision rationale:** The requested dicopanol is not medically necessary or appropriate. The requested medication is a liquid formulation of diphenhydramine. The California Medical Treatment Utilization Schedule does not address this type of medication. The Official Disability Guidelines recommend sedating antihistamines for short durations of treatment to assist with insomnia-related complaints when non-pharmacological measures have failed to provide re-establishment of normal sleep hygiene. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's sleep habits to support the need for a pharmacological intervention. Therefore, continued use would not be supported in this clinical situation. As such, the requested dicopanol 5 mg/ml 150 ml quantity of 1 is not medically necessary or appropriate.

**Fanatrex 25mg/ml, 420ml, QTY: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy/Neuropathic Pain; Anti Anxiety, Sleep Aid Page(s): 49; 18.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 16.

**Decision rationale:** The requested Fanatrex 25 mg/ml 420 ml quantity of 1 is not medically necessary or appropriate. This medication is a liquid formulation of gabapentin. The California Medical Treatment Utilization Schedule recommends anticonvulsants as a first line medication in the management of chronic pain. However, the clinical documentation does indicate that the injured worker has been using this medication for an extended duration. The California Medical Treatment Utilization Schedule recommends that ongoing use of anticonvulsants be supported by documented functional benefit and pain relief. The clinical documentation submitted for review does not provide an adequate assessment of pain relief or increased functionality related to medication usage to support continued use. Furthermore, the clinical documentation does not provide any justification for a liquid formulation over a more standard and traditional oral formulation of this medication. As such, the requested Fanatrex 25 mg/ml 420 ml quantity of 1 is not medically necessary or appropriate.

**Acupuncture right/left elbow/wrist 3 x per week for 6 weeks (18 visits): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The requested acupuncture right/left elbow/wrist 3 times per week times 6 weeks for a total of 18 visits is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends continued acupuncture treatment be based on documented functional benefit and evidence of significant functional increases and medication reduction. The clinical documentation submitted for review does indicate that the injured worker previously underwent acupuncture with good results. However, specific objective functional increases or specific reductions in medication were not provided. As such, the requested acupuncture right/left elbow/wrist 3 times per week times 6 weeks for a total of 18 visits is not medically necessary or appropriate.

**Terocin Patches, QTY: 1: Upheld**

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

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

**Decision rationale:** The requested Terocin patches are not medically necessary or appropriate. The requested topical medication is a compounded medication with methyl salicylate, menthol, capsaicin, and lidocaine. The California Medical Treatment Utilization Schedule does recommend the use of menthol and methyl salicylate in the management of osteoarthritic pain. However, the California Medical Treatment Utilization Schedule does not support the use of capsaicin unless all other first line medications have been exhausted. The clinical documentation submitted for review fails to provide any evidence that the injured worker has failed to respond

to first line treatments to include antidepressants and anticonvulsants. Therefore, the use of this medication would not be supported in this clinical situation. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment or dosage. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Terocin patches quantity of 1 are not medically necessary or appropriate.