

Case Number:	CM14-0190469		
Date Assigned:	11/21/2014	Date of Injury:	09/15/2010
Decision Date:	01/20/2015	UR Denial Date:	10/13/2014
Priority:	Standard	Application Received:	11/14/2014

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 Occupational 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:

This is a 30-year-old female with a 9/15/10 date of injury. According to an orthopedic consultation report, dated 8/29/14, the patient complained of sharp right shoulder pain, radiating down the arm to the fingers, associated with muscle spasms. She rated her pain as 7-8/10. She was status post carpal tunnel release surgery of the right wrist and stated that she continued to feel pain at the right wrist and thumb. She stated that medications offered her temporary relief of pain and improved her ability to have restful sleep. According to a provider note dated 9/16/14, Dicopanol contains Diphenhydramine and other proprietary ingredients. It is being used for the treatment of mild to moderate insomnia. Deprizine contains Ranitidine and other proprietary ingredients. It is used in patients who are on an oral NSAID at risk for gastrointestinal perforation/hemorrhage. Fanatrex contains Gabapentin and other proprietary ingredients, used for the treatment of neuropathic pain. Synapryn contains Tramadol and Glucosamine, as well as other proprietary ingredients. Tabradol contains Cyclobenzaprine, Methylsulfonylmethane, and other proprietary ingredients. Objective findings: tenderness to palpation of right shoulder, limited right shoulder range of motion, palpable tenderness noted over right wrist, limited right wrist range of motion, decreased sensation to pinprick along the course of the median nerve distribution in the right upper extremity. Diagnostic impression: right shoulder joint derangement, status post right carpal tunnel release with residual pain. Treatment to date includes medication management, activity modification, acupuncture, and TENS unit. A Utilization Review decision dated 10/13/14 denied the requests for Synapryn, Tabradol, Deprizine, Dicopanol, Fanatrex, Terocin patches, 1 periodic toxicological evaluation, and 18 physiotherapy sessions for right shoulder and right wrist. Regarding Synapryn, Tabradol, Deprizine, Dicopanol, and Fanatrex, the guidelines do not show scientific evidence for the use of these oral suspensions. In addition, the records do not reveal that this patient was unable to safely

swallow a pill or capsule. Regarding Terocin patches, a review of the available records failed to demonstrate that a trial of an oral anti-depressant or anti-epilepsy drug had been attempted and failed. There is no documentation showing that the patient had been intolerant to or unresponsive to previous treatments. Regarding toxicological evaluation, there is no documentation showing that the patient was utilizing opioids or other controlled substances. In addition, there is no documentation showing that the patient was new or was being considered for opioid therapy. Regarding physiotherapy treatments, the submitted records indicate the patient has completed at least 26 physical therapy sessions. Because the patient has completed more than the recommended physiotherapy already, and is still experiencing significant pain and decreased range of motion, more physiotherapy does not appear to be medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Synapryn 10mg/1ml oral suspension 500 ml: 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, Glucosamine Page(s): 78-81, 50.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The California MTUS states that Glucosamine and Chondroitin Sulfate are recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. Synapryn contains Tramadol and Glucosamine, as well as other proprietary ingredients. However, in the medical records provided for review, there is no documentation of significant pain reduction or improved activities of daily living. Guidelines do not support the continued use of opioid medications without documentation of functional improvement. In addition, there is no documentation of lack of aberrant behavior or adverse side effects, an opioid pain contract, urine drug screen, or CURES monitoring. There is no documentation that this patient has an arthritic condition. Furthermore, there is no rationale provided as to why this patient requires an oral suspension formulation and cannot tolerate the commercially available tablet/capsule formulation. Therefore, the request for Synapryn 10mg/1ml oral suspension 500 ml is not medically necessary.

Tabradol 1mg/ml oral suspension 250 ml: 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 Muscle Relaxants Page(s): 41-42.

Decision rationale: According to page 41 of the California MTUS 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. Treatment should be brief. There is also a post-operative use. The addition of Cyclobenzaprine to other agents is not recommended. Dicopanol contains Diphenhydramine and other proprietary ingredients. It is being used for the treatment of mild to moderate insomnia. Tabradol contains Cyclobenzaprine, Methylsulfonylmethane, and other proprietary ingredients. However, in the present case, it is unclear how long this patient has been taking Cyclobenzaprine. Guidelines do not support the long-term use of muscle relaxants. In addition, there is no documentation that the patient has had an acute exacerbation to his pain. Furthermore, there is no rationale provided as to why this patient requires an oral suspension formulation and cannot tolerate the commercially available tablet/capsule formulation. Therefore, the request for Tabradol 1mg/ml oral suspension 250 ml is not medically necessary.

Deprizine 15mg/ml oral suspension 250 ml: 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: FDA (Ranitidine)

Decision rationale: The California MTUS and Official Disability Guidelines do not address this issue. The FDA states that Ranitidine is indicated in the treatment of active gastric or duodenal ulcers, or for endoscopically diagnosed erosive esophagitis. Deprizine contains Ranitidine and other proprietary ingredients. It is used in patients who are on an oral NSAID at risk for gastrointestinal perforation/hemorrhage. However, in the present case, there is no rationale provided as to why this patient requires an oral suspension formulation and cannot tolerate the commercially available tablet/capsule formulation. Therefore, the request for Deprizine 15mg/ml oral suspension 250 ml is not medically necessary.

Dicopanol (Diphenhydramine) 5mg/ml oral suspension 150 ml: 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: FDA (Benadryl)

Decision rationale: The California MTUS and Official Disability Guidelines do not address this issue. The FDA states that Benadryl is indicated for the temporary relief of occasional headaches and minor aches and pains with accompanying sleeplessness. Dicopanol contains Diphenhydramine and other proprietary ingredients. It is being used for the treatment of mild to

moderate insomnia. However, in the present case, there is no documentation that the provider has addressed non-pharmacologic methods for sleep disturbances, such as proper sleep hygiene. In addition, there is no rationale provided as to why this patient requires an oral suspension formulation and cannot tolerate the commercially available tablet/capsule formulation. Therefore, the request for Dicopanol (Diphenhydramine) 5mg/ml oral suspension 150 ml is not medically necessary.

Fanatrex (Gabapentin) 25mg/ml oral suspension 420 ml: 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, Gabapentin Page(s): 16-18, 49. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA (Neurontin)

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines states that Gabapentin has been shown to be effective for the treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. Fanatrex contains Gabapentin and other proprietary ingredients, used for the treatment of neuropathic pain. However, in the present case, there is no rationale provided as to why this patient requires an oral suspension formulation and cannot tolerate the commercially available tablet/capsule formulation. Therefore, the request for Fanatrex (Gabapentin) 25mg/ml oral suspension 420 ml is not medically necessary.

Terocin patches: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Terocin Patches

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines states that topical Lidocaine in the formulation of a dermal patch has been designated for orphan status by the FDA for neuropathic pain. In addition, the California MTUS states that topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an anti-epilepsy drug such as Gabapentin or Lyrica). However, there is no documentation of the designated area for treatment as well as number of planned patches and duration for use (number of hours per day). In addition, there is no discussion in the reports reviewed regarding the patient failing treatment with a first-line agent such as Gabapentin. Furthermore, there is no documentation that the patient is unable to take oral medications. Therefore, the request for Terocin patches is not medically necessary.

1 Periodic toxicological evaluation: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 222-238, Chronic Pain Treatment Guidelines Drug Testing, Urine testing in ongoing opiate management Page(s): 43, 78.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines state that a urine analysis is recommended as an option to assess for the use or the presence of illegal drugs, to assess for abuse, to assess before a therapeutic trial of opioids, addiction, or poor pain control in patients under on-going opioid treatment. However, in the present case, the medical necessity for the oral suspension containing Tramadol was not established. There is no documentation that this patient is currently taking other opioid medications that would require monitoring. Therefore, the request for 1 periodic toxicological evaluation is not medically necessary.

18 Physiotherapy for the Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder (Acute & Chronic) Physical Therapy

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, General Approaches Page(s): 98-99. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Pain, Suffering, and the Restoration of Function Chapter 6, page 114 and Official Disability Guidelines (ODG) - Shoulder Chapter (Physical Therapy)

Decision rationale: The California MTUS stresses the importance of a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment is paramount. Physical Medicine Guidelines - Allow for fading of treatment frequency. Guidelines support up to 10 visits over 8 weeks for shoulder sprains. 18 sessions would exceed guideline recommendations. In addition, there is no documentation as to why this patient is unable to utilize an independent home exercise program. Therefore, the request for 18 physiotherapy visits for the right shoulder is not medically necessary.