

<b>Case Number:</b>	CM15-0182904		
<b>Date Assigned:</b>	09/23/2015	<b>Date of Injury:</b>	09/22/2014
<b>Decision Date:</b>	12/16/2015	<b>UR Denial Date:</b>	08/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Emergency Medicine

### 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 sustained an industrial-work injury on 9-22-14. A review of the medical records indicates that the injured worker is undergoing treatment for cervical strain and sprain, rule out cervical radiculopathy, bilateral shoulder sprain and strain, low back pain, lumbar strain and sprain rule out Herniated Nucleus Pulposus (HNP), rule out lumbar radiculopathy, bilateral hip strain and sprain, rule out internal derangement and bilateral ankle sprain and strain rule out internal derangement. Medical records dated (4-23-15 to 8-17-15) indicate that the injured worker complains of neck pain and muscle spasms with numbness and tingling in the upper extremities, bilateral shoulder pain, low back pain with radicular numbness and tingling in the bilateral lower extremities (BLE) and muscle spasms, bilateral hip pain and muscle spasms, and bilateral ankle pain. The pain is aggravated by activities and alleviated by medications and activity restriction. The pain is rated 6-7 out of 10 on the pain scale and has been unchanged. Per the treating physician report dated 8-17-15 the injured worker has not returned to work. The physical exam dated 8-17-15 reveals cervical tenderness, decreased range of motion, bilateral shoulder tenderness with decreased range of motion bilaterally, diminished sensation in the upper extremities, lumbar tenderness, decreased lumbar range of motion, tenderness to palpation of the bilateral trochanters and tenderness of the medial and lateral malleolus. Treatment to date has included pain medication, Cyclobenzaprine gel, Dicoprofanol, Deprazine, and Fanatrex (since at least 4-23-15, diagnostics, physical therapy, off of work and other modalities. The requested services included Cyclobenzaprine gel, Dicoprofanol 5mg-ml, Deprazine 5mg-ml, and Fanatrex 25mg-ml. The original Utilization review dated 8-20-

15 non-certified the request for Cyclobenzaprine gel, Dicopanol 5mg-ml, Deprizine 5mg-ml, and Fanatrex 25mg-ml.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Cyclobenzaprine gel:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**Decision rationale:** The request is for the use of a muscle relaxant to aid in pain relief. The MTUS guidelines state that the use of a medication in this class is indicated as a second-line option for short-term treatment of acute exacerbations of low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, which can increase mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain improvement. Efficacy appears to diminish over time, and prolonged use may lead to dependence. (Homik, 2004) Due to inadequate documentation of a recent acute exacerbation and poor effectiveness for chronic long-term use, the request is not medically necessary.

**Dicopanol 5mg/ml:** 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 Chapter, 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) Mental Illness and Stress/Diphenhydramine (Benadryl).

**Decision rationale:** The request is for the use of Diphenhydramine which is in the category of an antihistamine. The MTUS guidelines are silent regarding this topic. The ODG states the following regarding its use: Not recommended. See Insomnia treatment, where sedating antihistamines are not recommended for long-term insomnia treatment. The AGS updated Beers criteria for inappropriate medication use includes diphenhydramine. (AGS, 2012) Anticholinergic drugs, including diphenhydramine, may increase the risk for dementia by 50% in older adults. There is an obvious dose-response relationship between anticholinergic drug use and risk of developing dementia, but chronic use, even at low doses, would be in the highest risk category. While there is awareness that these drugs may cause short-term drowsiness or confusion, which is included in the prescribing information, there is no mention of long-term effects on cognition, and generally awareness of this issue is very low, and both the public and doctors need to be encouraged to use alternative treatments where possible. (Gray, 2015) As stated above, the use of this medication is not indicated for use in this patient for insomnia.

There is inadequate documentation of the reasoning for its use for other indications. As such, the request is not medically necessary.

**Deprizine 5mg/ml:** 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 Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** The request is for the use of a medication in the class of an acid reducing medication. The guidelines do not specifically address or advise the use of an H2 blocker but does make recommendations regarding medications in the same category classified as proton pump inhibitors. This is usually given for patients with esophageal reflux, gastritis, or peptic ulcer disease. It can also be used as a preventative measure in patients taking non-steroidal anti-inflammatory for chronic pain which have side effects including gastrointestinal disease. The MTUS guidelines states that patients who are classified as intermediate or high risk, should be treated prophylactically with a proton pump inhibitor or Misoprostol. Criteria for risk are as follows: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Due to the fact the patient does not meet to above stated criteria, the request for use is not medically necessary.

**Fanatrex 25mg/ml:** 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 Chapter, Compounded medications.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

**Decision rationale:** The request is for the use of a medication in the category of an anti-epileptic drug (AED). These medications are recommended for certain types of neuropathic pain. Most of the randomized clinical control trials involved include post-herpetic neuralgia and painful polyneuropathy such as in diabetes. There are few trials which have studied central pain or radiculopathy. The MTUS guidelines state that a good response to treatment is 50% reduction in pain. At least a 30% reduction in pain is required for ongoing use, and if this is not seen, this should trigger a change in therapy. Their also should be documentation of functional improvement and side effects incurred with use. Disease states which prompt use of these medications include post-herpetic neuralgia, spinal cord injury, chronic regional pain syndrome, lumbar spinal stenosis, post-operative pain, and central pain. There is inadequate evidence to support use in non-specific axial low back pain or myofascial pain. In this case, there is lack of documentation of functional improvement or screening measures as required. As such, the request is not medically necessary.