MAXIMUS Federal Services

Case Number:	CM15-0188789		
Date Assigned:	09/30/2015	Date of Injury:	02/26/2015
Decision Date:	12/10/2015	UR Denial Date:	09/18/2015
Priority:	Standard	Application Received:	09/25/2015

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: Tennessee, Florida, Ohio
Certification(s)/Specialty: Surgery, Surgical Critical Care

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 33 year old male, who sustained an industrial injury on 2-26-2015. The medical records indicate that the injured worker is undergoing treatment for cervical spine sprain-strain, rule out herniated nucleus pulposus, rule out cervical radiculopathy, bilateral shoulder sprain-strain, rule out internal derangement, bilateral wrist and hand pain, bilateral hand ganglion cyst, rule out bilateral carpal tunnel syndrome, rule out bilateral hand tenosynovitis, thoracic spine pain, thoracic spine sprain-strain, thoracic spine herniated nucleus pulposus, low back pain, lumbar spine sprain-strain, rule out herniated nucleus pulposus, rule out lumbar radiculopathy, and left ankle sprain-strain, rule out internal derangement. According to the progress report dated 8-28-2015, the injured worker presented with complaints of sharp, stabbing neck pain (6-7 out of 10), dull, achy, and often times stabbing bilateral shoulder pain (5-6 out of 10), dull, achy bilateral wrist and hand pain (6 out of 10), dull, achy, and often times sharp and stabbing mid back pain (6 out of 10), sharp, burning low back pain (6-7 out of 10), and dull, achy, and often times sharp and stabbing left ankle pain (5 out of 10). The physical examination of the cervical spine reveals tenderness to palpation over the suboccipital, scalene, and sternocleidomastoid muscles, as well as the bilateral brachial plexus. There are trigger points noted at the bilateral upper trapezius. Range of motion is restricted. There is a positive cervical distraction and maximal foraminal compression tests. Examination of the bilateral shoulders reveals tenderness to palpation at the supraspinatus and infraspinatus, as well as the subscapularis on the right side. Range of motion is limited. Examination of the bilateral wrists-hands reveals tenderness to palpation at the flexor tendon attachment sites, over the carpal bones

and at the thenar and hypothenar eminences. Examination of the thoracic spine reveals tenderness to palpation over the spinous process T2, T3, T4, and T5, bilateral thoracic paraspinal muscle guarding, restricted range of motion, and positive Kemp's test. Examination of the lumbar spine reveals tenderness to palpation at the quadratus lumborum muscles bilaterally and the spinous processes L3-5, limited range of motion, and positive straight leg raise test bilaterally. Examination of the left ankle reveals tenderness to palpation at the anterior talofibular ligament and the peroneus brevis tendon attachment sites, decreased range of motion, and positive anterior-posterior drawer and inversion-eversion tests. There is also tenderness to palpation at the 2nd to 4th dorsal extensor muscle compartments bilaterally. Range of motion is reduced. The current medications are Ketoprofen cream, Cyclobenzaprine 5% cream, Synapryn, Tabradol, Deprizine, Dicopanol, and Fanatrex. There is documentation of ongoing treatment with the above mentioned medications since at least 3-17-2015. Previous diagnostic testing includes MRI studies. Treatments to date include medication management. Work status is described as off work. The original utilization review (9-18-2015) had non-certified a request for Ketoprofen cream, Cyclobenzaprine 5% cream, Synapryn, Tabradol, Deprizine, Dicopanol, and Fanatrex.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen Cream 20% 167gm: 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): Topical Analgesics.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. The California MTUS guidelines address the topic of NSAID prescriptions by stating, "A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics." Furthermore, MTUS guidelines specifically state regarding topical Non-steroidal anti-inflammatory agents (NSAIDs): "The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period." Compounded medications are not subject to FDA oversight for purity or efficacy. The medical records do not support that the patient has osteoarthertitis or a contraindication to other non-opioid analgesics. Therefore, based on the submitted medical documentation, the request for ketoprofen cream is not medically necessary.

Cyclobenzaprine 5% Cream 110gm: 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): Topical Analgesics.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. Per the California MTUS Chronic Pain guidelines, topical analgesics are not recommended as an option for chronic pain control and are largely experimental in use with few randomized control trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended as a whole. The requested cream is a combination of multiple medications. Compounded medications are not FDA approved or recommended by ODG guidelines due to concerns of purity and efficacy. Hence, the request for this compounded medication is not appropriate or indicated by MTUS and ODG guidelines. Therefore, based on the submitted medical documentation, the request for cyclobenzaprine cream is not medically necessary.

Synapryn 10mg/1ml oral suspension 500ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Glucosamine (and Chondroitin Sulfate).

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. Synapryn, per the National Library of Medicine (NLM), is an amalgam of tramadol and glucosamine. While page 50 of the MTUS Chronic Pain Medical Treatment Guidelines notes that glucosamine is indicated in the treatment of arthritis and, in particular, that associated with knee arthritis, in this case, however, there was no mention of the applicant's having any issues with either arthritis and/or knee arthritis for which usage of glucosamine would have been indicated. Since the glucosamine ingredient in the Synapryn amalgam is not recommended, the entire amalgam is not recommended. Therefore, based on the submitted medical documentation, the request for synaprn is not medically necessary.

Tabradol 1mg/ml oral suspension 250ml: Upheld

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

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

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. Tabradol, per the National Library of Medicine (NLM), is an amalgam of cyclobenzaprine and MSM. However, page 113 of the MTUS Chronic Pain Medical Treatment Guidelines notes that cyclobenzaprine is not recommended

for topical compound formulation purposes. Since one or more ingredients in the amalgam is not recommended, the entire amalgam is not recommended, per page 113 of the MTUS Chronic Pain Medical Treatment Guidelines. Therefore, based on the submitted medical documentation, the request for tabradol is not medically necessary.

Deprizine 15mg/ml oral suspension 250ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steriodal anti-inflammatory drugs), NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. While the MTUS Chronic Pain Medical Treatment Guidelines notes that H2 antagonists such as ranitidine (Deprizine) are indicated in the treatment of NSAID-induced dyspepsia, in this case, however, there was no mention of the applicant's having any issues with reflux, heartburn, and/or dyspepsia, either NSAID-induced or stand-alone, on or around the date in question. Therefore, based on the submitted medical documentation, the request for deprizine is not medically necessary.

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

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Nonprescription medications.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. While the MTUS does not specifically address the topic of Dicopanol (diphenhydramine), the MTUS Guideline in ACOEM Chapter 3, page 47 does stipulate that it is incumbent upon a prescribing provider to discuss the efficacy of the medication for the particular condition for which it is being prescribed. Here, the attending provider did not clearly state or stipulate for which condition or conditions Dicopanol (diphenhydramine) was being prescribed. While the National Library of Medicine (NLM) acknowledges that Dicopanol is indicated in the treatment of allergic reactions, motion sickness, and/or parkinsonism, in this case, however, there was no mention of the applicant's having any issues with parkinsonism, motion sickness, etc., on or around the date in question. Therefore, based on the submitted medical documentation, the request for dicopanol is not medically necessary.

Fanatrex (Gabapentin) 25mg/ml oral suspension 420ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, and Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. While page 49 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that gabapentin is indicated in the treatment of localized peripheral pain or neuropathic pain as was/is present here in the form of the applicant's digital paresthesias, this recommendation is, however, qualified by commentary made on page 47 of the ACOEM Practice Guidelines and on page 7 of the MTUS Chronic Pain Medical Treatment Guidelines to the effect that an attending provider should incorporate some discussion of "cost" into his choice of pharmacotherapy. Here, the attending provider did not clearly outline why a custom compounded, brand-name Fanatrex agent was being employed in favor of generic gabapentin. The attending provider, thus, did not incorporate any discussion of cost into his choice of pharmacotherapy. Therefore, based on the submitted medical documentation, the request for fanatrex is not medically necessary.