

<b>Case Number:</b>	CM15-0050980		
<b>Date Assigned:</b>	04/15/2015	<b>Date of Injury:</b>	03/04/2014
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	03/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/17/2015

### 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: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 patient is a 60-year-old female who reported an injury on 03/04/2014. The mechanism of injury involved cumulative trauma. The current diagnoses include cervical sprain, cervical degenerative disc disease, cervical radiculopathy, left shoulder labral tear, left shoulder rotator cuff repair, left shoulder ac arthrosis, left shoulder tendinitis, left shoulder bursitis, low back pain, lumbar spine sprain, lumbar herniated nucleus pulposus, lumbar spine degenerative disc disease, lumbar facet arthropathy, lumbar radiculopathy, bilateral knee sprain, bilateral knee internal derangement, left knee lateral meniscus tear, right knee medial meniscus tear, and bilateral knee osteoarthritis. The injured worker presented on 01/26/2015 for a follow-up evaluation with complaints of radicular neck pain, left shoulder pain, radicular low back pain, and bilateral knee pain. Upon examination, there was tenderness to palpation over the cervical paraspinal muscles bilaterally, limited cervical range of motion, tenderness at the upper trapezius and rhomboid areas, limited range of motion of the bilateral shoulders, diminished sensation over the C5-T1 dermatomes in the bilateral upper extremities, 4/5 motor weakness bilaterally, tenderness to palpation over the lumbar paraspinal muscles and over the lumbosacral junction, limited lumbar range of motion, tenderness over the medial and lateral joint line, tenderness over the patellofemoral joint line, decreased sensation at the L4-S1 dermatomes bilaterally, and 4/5 motor weakness in the bilateral lower extremities. Treatment recommendations at that time included continuation of the current medication regimen. There was no Request for Authorization form submitted for review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Terocin Patches:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 111-113.

**Decision rationale:** California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. In this case, there was no documentation of a failure of first line oral medication. There was also no documentation of an improvement in symptoms despite the ongoing use of this medication. The request as submitted failed to indicate the strength, frequency, and quantity. Given the above, the request is not medically necessary.

**Periodic UA toxicological evaluation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG Pain Chapter, Urine Drug Testing (UDT).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 43, 77, and 89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Urine Drug Testing.

**Decision rationale:** California MTUS Guidelines state drug testing is recommended as an option, using a urine drug screen to assess for the use or presence of illegal drugs. The Official Disability Guidelines state the frequency of urine drug testing should be based on documented evidence of risk stratification. Patients at low risk of addiction or aberrant behaviors should be tested within 6 months of initiation of therapy and on a yearly basis thereafter. As per the clinical notes submitted, there is no mention of non-compliance or misuse of medication. There is no indication that this injured worker falls under a high-risk category that would require frequent monitoring. Therefore, the current request is not medically appropriate.

**Ketoprofen 20% cream 167 gm:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 111-113.

**Decision rationale:** The California MTUS Guidelines state any compounded product that contains at least one drug that is not recommended, is not recommended as a whole. The only FDA approved topical NSAID is diclofenac. The request for a compounded cream containing ketoprofen would not be supported. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

**Cyclobenzaprine 5% cream 110gm:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

**Decision rationale:** The California MTUS Guidelines state any compounded product that contains at least one drug that is not recommended, is not recommended as a whole. Muscle relaxants are not recommended for topical use. The request for a compounded cream containing cyclobenzaprine would not be supported. There is also no frequency listed in the request. As such, the request is not medically necessary.

**Fanatrex Gabapentin 25mg/ml oral suspension 420ml:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter, Compound Drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-19.

**Decision rationale:** The California MTUS Guidelines state anti-epilepsy drugs are recommended for neuropathic pain. Gabapentin is recommended for treatment of diabetic painful neuropathy and post-herpetic neuralgia. It is also considered first line treatment for neuropathic pain. The medical necessity for gabapentin with other proprietary ingredients has not been established. Additionally, there is no indication that this injured worker is unable to swallow pills or capsules. Given the above, the request is not medically appropriate.

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

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and

documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the clinical notes submitted, there was no evidence of a failure of non-opioid analgesics. There was no documentation of a written consent or agreement for the chronic use of an opioid. Recent urine toxicology reports were not provided. Additionally, there is no indication that this injured worker is unable to swallow pills or capsules. Given the above, the request is not medically appropriate.

**Tabradol 1mg/ml oral suspension 250ml:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 63-66.

**Decision rationale:** The California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations in patients with chronic low back pain. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. As per the clinical notes submitted, there was no objective evidence of palpable muscle spasm or spasticity upon examination. Additionally, there is no indication that this injured worker is unable to swallow pills or capsules. Given the above, the request is not medically appropriate.

**Deprizine 15mg/ml oral suspension 250ml:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain Chapter, Compound Drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**Decision rationale:** The California MTUS Guidelines state proton pump inhibitors are recommended for patients with intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor. There is no evidence of cardiovascular disease or increased risk factors for gastrointestinal events. Additionally, there is no indication that this injured worker is unable to swallow pills or capsules. Given the above, the request is not medically appropriate.

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

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation  
<http://www.drugs.com/pro/diphenhydramine.html>.

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

**Decision rationale:** The Official Disability Guidelines state diphenhydramine is a sedating antihistamine, often utilized as an over-the-counter medication for insomnia treatment. As per the clinical notes submitted, there is no indication of chronic insomnia or a chronic condition where an antihistamine is necessary. There is also no indication that this injured worker cannot safely swallow pills or capsules. The medical necessity has not been established. As such, the request is not medically appropriate.