

<b>Case Number:</b>	CM15-0064598		
<b>Date Assigned:</b>	05/13/2015	<b>Date of Injury:</b>	01/27/2014
<b>Decision Date:</b>	09/17/2015	<b>UR Denial Date:</b>	03/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/06/2015

### 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 59 year old female, who sustained an industrial injury on 1/27/14. She reported right wrist and hand pain. The injured worker was diagnosed as having right wrist/hand sprain/strain, rule out right wrist internal derangement, status post right wrist/hand surgery, and status post right wrist fracture. Treatment to date has included physical therapy, acupuncture, shockwave therapy, and medications. Physician's reports dated 2/10/15 and 3/10/15 noted pain was rated as 7-8/10. A report dated 3/10/15 noted physical examination findings of decreased right wrist range of motion, diminished light touch sensation over the C5-T1 dermatomes in the right upper extremity and decreased motor strength secondary to pain in the right upper extremity. Currently, the injured worker complains of right wrist pain with weakness, numbness, and tingling of the hand and fingers. The treating physician requested authorization for Synapryn 10mg/1ml oral suspension 500ml, Tabradol 1mg/ml oral suspension 250ml, Deprizine 15mg/ml oral suspension 250ml, Dicopanol 5mg/ml oral suspension 150ml, Fanatrex 25mg/ml oral suspension 420ml, electromyogram/nerve conduction velocity of bilateral upper extremities, Capsaicin, and Menthol.

### 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 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 Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 Page(s): 50 of 127.

**Decision rationale:** Recommended as an option given its low risk in patients with moderate arthritis pain; especially for knee osteoarthritis. Studies have demonstrated a highly significant efficacy for crystalline glucosamine sulphate (GS) on all outcomes, including joint space narrowing, pain, mobility, safety, and response to treatment, but similar studies are lacking for glucosamine hydrochloride (GH). (Richy, 2003) (Ruane, 2002) (Towheed-Cochrane, 2001) (Braham, 2003) (Reginster, 2007) A randomized, double-blind placebo controlled trial, with 212 patients, found that patients on placebo had progressive joint-space narrowing, but there was no significant joint-space loss in patients on glucosamine sulphate. In this case, the use of glucosamine is not indicated. The patient does not meet the diagnostic criteria set for use. As such, the request is not certified and therefore 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 Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 Page(s): 41-42 of 127.

**Decision rationale:** The request is for the use of Cyclobenzapril. This medication is classified as a muscle relaxant and central nervous system depressant with side effects including drowsiness and dizziness. The MTUS guidelines states that it is indicated for short term use for low back pain. The effect seems to be greatest the first 4 days of use which suggests that treatment should be brief. In this case, due to the duration of treatment, further use would not be indicated. As such, the request would not be certified and therefore is not medically necessary.

**Deprizine 15ml-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 Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 Page(s): 68 of 127.

**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-

inflammatories 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 certified and therefore is not medically necessary.

**Dicopanol 5mg/ml oral suspension 150ml: 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 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 also no other listed indication listed in the guidelines regarding its use for the injuries listed. There is also no documentation that the patient requires an oral suspension instead of tablets or capsules. There is inadequate documentation of the reasoning for its use for other indications. As such, the request is not certified and therefore is not medically necessary.

**Fanatrex 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 Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 Page(s): 16-17 of 127.

**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. There 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 inadequate documentation of a condition which would support the use of an anti-epileptic drug. The records also do not reveal functional improvement or screening measures as required. As such, the request is not certified and therefore is not medically necessary.

**EMG/NCV bilateral upper extremities: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 178, 261 and 254. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Carpal Tunnel Syndrome (Acute & Chronic), Neck & Upper Back (Acute & Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper back Nerve conduction studies.

**Decision rationale:** Not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) (Lin, 2013) While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other than a cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. (Emad, 2010) (Plastaras, 2011) (Lo, 2011) (Fuglsang-Frederiksen, 2011) See also the Shoulder Chapter, where nerve conduction studies are recommended for the diagnosis of TOS (thoracic outlet syndrome). Also see the Carpal Tunnel Syndrome Chapter for more details on NCS. Studies have not shown portable nerve conduction devices to be effective. In this case, the use of this diagnostic test is not supported. There are inadequate physical exam findings documented to justify this evaluation other than diminished light touch. As such, the request is not certified and therefore is not medically necessary.

**Unknown prescription Capsaicin: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 Page(s): 111 to 113 of 127.

**Decision rationale:** The request is for the use of a compounded medication for topical use to aid in pain relief. In this case, the topical treatment contains Capsaicin. Qualifying factors for this product is indicated by the following per the guidelines: Capsaicin: Recommended only as an option in patients who have not responded or are intolerant to other treatments. Formulations: Capsaicin is generally available as a 0.025% formulation (as a treatment for osteoarthritis) and a 0.075% formulation (primarily studied for post-herpetic neuralgia, diabetic neuropathy and post-mastectomy pain). There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. Indications: There are positive randomized studies with capsaicin cream in patients with osteoarthritis, fibromyalgia, and chronic non-specific back pain, but it should be considered experimental in very high doses. Although topical capsaicin has moderate to poor efficacy, it may be particularly useful (alone or in conjunction with other modalities) in patients whose pain has not been controlled successfully with conventional therapy. The number needed to treat in musculoskeletal conditions was 8.1. The number needed to treat for neuropathic conditions was 5.7. (Robbins, 2000) (Keitel, 2001) (Mason-BMJ, 2004) In this case, as stated above, the patient would not qualify for the use of capsaicin based on the diagnosis. As such, the request is not certified and therefore is not medically necessary.

**Unknown prescription Menthol:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49.

**Decision rationale:** The request is for the topical use of menthol. The MTUS and ACOEM as well as ODG do not comment specifically regarding this topic. The ACOEM guidelines do generally state that the use of topical therapy for pain control does not have good evidence regarding efficacy. In this case, the use of topical menthol would not be supported. This is secondary to poor scientific evidence for the patient's condition. As such, the request is not certified and therefore is not medically necessary.