MAXIMUS Federal Services

Case Number:	CM15-0067543		
Date Assigned:	04/20/2015	Date of Injury:	07/24/2014
Decision Date:	09/14/2015	UR Denial Date:	03/30/2015
Priority:	Standard	Application Received:	04/09/2015

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: Texas, Florida
Certification(s)/Specialty: Anesthesiology, Pain Management

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 57-year-old female, who sustained an industrial injury on July 24, 2014 while working as an egg packager. The injured worker has been treated for neck and low back complaints. The diagnoses have included cervical myospasms, thoracic myospasms, lumbar radiculitis, planter fasciitis, and rule out cervical disc protrusion, rule out thoracic disc protrusion, chronic pain, anxiety and depression. Treatment to date has included medications, radiological studies, injections, physical therapy, acupuncture treatments and extracorporeal shockwave therapy. Current documentation dated March 24, 2015 notes that the injured worker reported constant moderate neck, upper, mid and low back pain. The injured worker also noted left foot pain, depression and anxiety. Objective findings of the cervical spine included tenderness to palpation over the paravertebral muscles. Range of motion was noted to be painful and flexion was decreased. Lumbar spine examination revealed a painful and decreased range of motion. A straight leg raise test was negative. Examination of the left foot was normal. The treating physician's plan of care included a request for the medications Ketoprofen 20% cream 127grams, Cyclobenzaprine 5% cream 110 grams, Synapryn 10 mg/ml 500 ml, Tabradol 1 mg/ml 250 ml, Deprizine 15 mg/ml 250 ml, Dicopanol 5 mg/ml 150 ml and Fanatrex 25 mg/ml 420 ml.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 20% cream 167g: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-73. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter NSAID Topical Analgesics.

Decision rationale: The CA MTUS and the ODG guidelines recommend that NSAIDs can be utilized for the treatment of exacerbation of musculoskeletal pain. The use of topical NSAIDs is associated with the development of tolerance reduction in efficacy. Topical ketoprofen is associated with the development of photosensitive dermatitis. The records did not show a contraindication for the development of oral NSAID. The criteria for the use of Ketoprofen 20% cream 167g were not medically necessary.

Cyclobenzaprine 5% cream 110g: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

Decision rationale: The CA MTUS and the ODG guidelines recommend that muscle relaxants can be utilized for the short term treatment of exacerbation of musculoskeletal pain when standard treatment with oral NSAIDs and PT have failed. The records indicate that the patient is utilizing Cyclobenzaprine in both topical and oral formulations. There is lack of guidelines support for the utilization of topical formulations of Cyclobenzaprine. The criteria for the use of cyclobenzaprine 5% cream 110g were not medically necessary.

Synapryn 10mg/ml 500ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=594bad96.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111, 113, 119. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Opioids.

Decision rationale: The CA MTUS and the ODG guidelines did not recommend that the use of compounded formulations of active medications with non-standardized inactive ingredients. It is recommended that medications be utilized individually so that efficacy can be evaluated. There is no documentation that the patient could not utilize standard formulations of Tramadol without

the inactive ingredients. The Synapryn contains Tramadol and glucosamine products. The criterion for the use of Synapryn 10mg/ml 500ml was not medically necessary.

Tabradol 1mg/ml 250ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG TWC Pain Procedure Summary, http://www.drugs.com/cons/fusepaq-tabradol.html.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Muscle Relaxants.

Decision rationale: The CA MTUS and the ODG guidelines recommend that muscle relaxants can be utilized for the short term treatment of exacerbation of musculoskeletal pain when standard treatment with oral NSAIDs and PT have failed. The records indicate that the patient is utilizing Cyclobenzaprine in both topical and oral formulations. There is lack of guidelines support for the utilization of non-standard formulations of Cyclobenzaprine with inactive ingredients. The criteria for the use of Tabradol 1mg/ml 250ml were not medically necessary.

Deprizine 15mg/ml 250ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-73. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter NSAIDs.

Decision rationale: The CA MTUS and the ODG guidelines did not recommend that use of compounded formulations of active medications with not standardized inactive ingredients. It is recommended that medications be utilized individually so that efficacy can be evaluated. The Deprizine product contains ranitidine and inactive ingredients in liquid formulation. There is no documentation that the patient could not utilize standard formulations of ranitidine without the inactive ingredients. There is no documented indication for long-term use of ranitidine. The criteria for the use of Deprizine 15mg/ml 250ml were not medically necessary.

Dicopanol 5mg/ml 150ml: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MD Consult Drug Monography, http://www.drugs.com/pro/dicopanol.html.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

Decision rationale: The CA MTUS and the ODG guidelines did not recommend that use of compounded formulations of active medications with not standardized inactive ingredients. It is recommended that medications be utilized individually so that efficacy can be evaluated. The Dicopanol product contains diphenhydramine with inactive ingredients. There was no documentation for the indication for long-term treatment with antihistamine medications. There is no documentation that the patient could not utilize standard formulations of the antihistamine diphenhydramine without the inactive ingredients. The criteria for the use of Dicopanol 5mg/ml 150ml were not medically necessary.

Fanatrex 25mg/ml 420ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs). Decision based on Non-MTUS Citation http://www.drugs.com/pro/fanatrex.html.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-22. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Anti-epileptics.

Decision rationale: The CA MTUS and the ODG guidelines did not recommend that use of compounded formulations of active medications with not standardized inactive ingredients. It is recommended that medications be utilized individually so that efficacy can be evaluated. The Fanatrex contains Gabapentin and inactive ingredients. There is no documentation that the patient could not utilize standard formulations of Gabapentin without the inactive ingredients. The criteria for the use of Fanatrex 25mg/ml 420ml were not medically necessary.