

Case Number:	CM14-0153975		
Date Assigned:	09/23/2014	Date of Injury:	12/01/2013
Decision Date:	11/14/2014	UR Denial Date:	09/04/2014
Priority:	Standard	Application Received:	09/22/2014

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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 an injured worker with bilateral wrist conditions. The primary treating physician's report dated July 21, 2014 documented that the patient sustained cumulative injuries during the period from December 1, 2013 to April 26, 2014 while working. The patient's usual and customary duties consisted of carrying heavy boxes and packing frozen fruits and vegetables. She developed pain in her wrists. During the course of her employment, she noted a gradual onset of pain in both wrists, due to the repetitive work duties. The patient reported the injury and was referred for treatment. She underwent physical therapy and received medications. The patient complains of burning, throbbing bilateral wrist pain. Her pain is described as constant, moderate to severe. The pain is aggravated by gripping, grasping, reaching pulling, and lifting. She also complains of weakness, numbness, tingling, and pain radiating to the hands and fingers. The patient has asthma. The patient denies any prior surgeries. The patient denies any prior motor vehicle accidents. The patient has allergy to Penicillin and Aspirin. The patient denies alcohol consumption. The patient is a smoker. Physical examination was documented. On examination, the patient is awake, alert, oriented and appears to be in no acute distress. There is mild swelling noted over the volar aspect of the left wrist. The patient is wearing a left wrist brace. There is tenderness to palpation at the carpal bones. There is also tenderness to palpation at the left anatomical snuff box. Motor strength is 4/5 in all the represented muscle groups in the left upper extremity. Diagnoses were bilateral wrist pain, bilateral wrist internal derangement, right wrist ganglion cyst, bilateral wrist subchondral cyst, and bilateral wrist effusion. Treatment plan included medications. Utilization review determination date was 9/4/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 20% cream, 165g TID #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, NSAIDs Page(s): 69, 111-112.

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

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines addresses topical analgesics. Topical Analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. Ketoprofen is a non-FDA-approved agent. Ketoprofen is not currently FDA approved for topical application. Medical records document the diagnoses of bilateral wrist pain, bilateral wrist internal derangement, right wrist ganglion cyst, bilateral wrist subchondral cyst, and bilateral wrist effusion. MTUS guidelines do not support the use of topical Ketoprofen. Therefore, the request for Ketoprofen 20% cream, 165g TID #1 is not medically necessary.

Deprizine 250ml 5mg/ml oral suspension, 10ml QD #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, NSAIDs Page(s): 69, 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines address NSAIDs and gastrointestinal risk factors. Proton Pump Inhibitor (PPI), e.g. Omeprazole (Prilosec), is recommended for patients with gastrointestinal risk factors. MTUS does not address Deprizine (Ranitidine). American College of Gastroenterology Guidelines for Prevention of NSAID-Related Ulcer Complications (2009) reported that systematic reviews have shown that H2RA histamine-2-receptor antagonist medications are effective in reducing the risk of NSAID-induced endoscopic gastric ulcers. Economic modeling suggests that cotherapy with an H2RA may be a cost-effective strategy for prevention of ulcer bleeding in NSAID users. Medical records do not document gastrointestinal symptoms or conditions. Topical NSAIDs were determined to be not medically necessary. The primary treating physician's report dated July 21, 2014 does not document oral NSAID use. Because the patient does not have documented gastrointestinal symptoms, conditions, or risk factors, the use of Deprizine (Ranitidine) is not supported. Therefore, the request for Deprizine 250ml 5mg/ml oral suspension, 10ml QD #1 is not medically necessary.

Dicopanol 150ml 5mg/mo oral suspension 1ml PO HS #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, NSAIDs Page(s): 69, 111-112.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Insomnia treatment, Dicopanol (Diphenhydramine) <http://www.drugs.com/pro/dicopanol.html>

Decision rationale: Medical Treatment Utilization Schedule (MTUS) does not address Dicopanol (diphenhydramine) for insomnia treatment. Official Disability Guidelines (ODG) guidelines state that over-the-counter sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine). Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. Side effects include urinary retention, blurred vision, orthostatic hypotension, dizziness, palpitations, increased liver enzymes, drowsiness, dizziness, grogginess and tiredness. Regarding insomnia treatment, after a few weeks, the recommendation is to discontinue the medication. Patients do better in the long term if medication is stopped after 6 weeks. Dicopanol is Diphenhydramine (Benadryl) compounded oral suspension. Medical records indicate that Dicopanol, which is a Diphenhydramine (Benadryl) suspension, was requested for the patient's sleep complaints. ODG guidelines do not support the use of over-the-counter antihistamines such as Diphenhydramine, which is the medication in Dicopanol suspension, for insomnia treatment. Therefore, the request for Dicopanol 150ml 5mg/ml oral suspension 1ml PO HS #1 is not medically necessary.

Cyclobenzaprine 5% cream, 100g, TID #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, NSAIDs Page(s): 69, 111-112.

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

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines address topical analgesics. Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. There is no evidence for use of a muscle relaxant as a topical product. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Medical records document the diagnoses of bilateral wrist pain, bilateral wrist internal derangement, right wrist ganglion cyst, bilateral wrist subchondral cyst, and bilateral wrist effusion. MTUS guidelines do not support the use of topical Cyclobenzaprine. Therefore, the request for Cyclobenzaprine 5% cream, 100g, TID #1 is not medically necessary.