

Case Number:	CM14-0165703		
Date Assigned:	10/28/2014	Date of Injury:	05/30/2014
Decision Date:	12/15/2014	UR Denial Date:	09/16/2014
Priority:	Standard	Application Received:	10/08/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Management 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 a 33 year old female with date of injury 5/30/14 that resulted from being pushed causing her to fall and hit her head and back. The treating physician report dated 6/23/14 indicates that the patient presents with pain affecting the head, neck, bilateral shoulders, bilateral wrists, mid back, low back, right knee and right ankle. The physical examination findings reveal tenderness, decreased ranges of motion, positive orthopedic testing, decreased sensation to light touch and pinprick in upper extremities and decreased motor strength of the upper extremities rated a 4/5. Prior treatment history includes medications. The current diagnoses are: 1. Headaches 2. Cervical, thoracic and lumbar s/s 3. Bilateral shoulder, wrist and right knee s/s 4. Rule out cervical, thoracic and lumbar HNP The utilization review report dated 9/16/14 denied the request for Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclobenzaprine, Terocin patches, Ketoprofen cream, TENS unit with supplies, Hot and Cold therapy unit and supplies purchase based on the MTUS Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Deprizine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-Steroidal Anti-Inflammatory Drugs) Page(s): 67-73.

Decision rationale: The patient presents with pain affecting the head, neck, bilateral shoulders and bilateral wrists, mid back, low back, right knee and right ankle. The current request is for Deprizine. The treating physician report dated 6/23/14 states, "Deprizine contains ranitidine and other proprietary ingredients. Many patients who are on an oral NSAID to treat acute or chronic pain are at risk for GI perforation/hemorrhage. The MTUS Guidelines state, "Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." However, in this patient, the patient does not have dyspepsia with NSAID. The provider is using H2 blocker for prophylaxis. MTUS require documentation of GI risk assessment such as age >64, concurrent use of ASA, anticoagulant, history of peptic ulcer disease, etc., for prophylactic use of PPI. In reviewing the treating physician reports supplied there are no GI complaints documented. As such, Deprizine is not medically necessary.

Dicopanol: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Rxlist.com

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

Decision rationale: The patient presents with pain affecting the head, neck, bilateral shoulders, bilateral wrists, mid back, low back, right knee and right ankle. The current request is for Dicopanol. The provider states, "Dicopanol contains diphenhydramine and other proprietary ingredients. Many pharmacological agents currently on the market for the treatment of insomnia include benzodiazepines and non-benzodiazepines hypnotics." The MTUS Guidelines do not address Dicopanol. In reviewing the ODG Guidelines, there is no support of diphenhydramine on a long-term basis for insomnia as tolerance seems to develop within a few days. In addition to the lack of guideline support the treating physician has failed to document the dosage and frequency for this request making the prescription invalid. Therefore, Dicopanol is not medically necessary.

Fanatrex: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 18,19.

Decision rationale: The patient presents with pain affecting the head, neck, bilateral shoulders, bilateral wrists, mid back, low back, right knee and right ankle. The current request is for

Fanatrex. Fanatrex contains gabapentin and other proprietary ingredients. This patient does present with radiating symptoms of the lower extremities, and there may be a component of radicular symptoms or neuropathic pain. The use of gabapentin is appropriate and consistent with MTUS Guidelines. However, it is not known why this provider is prescribing an oral suspension of this medication. There are no documentations in the progress report that the patient has any problems that would preclude use of oral pill medications. Furthermore, Fanatrex contains "other proprietary ingredients" that is not disclosed. Without knowing what is contained in these medications, it cannot be considered for authorization and the provider failed to document the dosage and frequency for this prescription. Therefore, Fanatrex is not medically necessary.

Synapryn: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 113 and 74-96.

Decision rationale: The patient presents with pain affecting the head, neck, bilateral shoulders, bilateral wrists, mid back, low back, right knee and right ankle. The current request is for Synapryn. Synapryn is an oral suspension that contains tramadol and glucosamine as well as other proprietary ingredients. The MTUS Guidelines do support Tramadol for chronic moderately severe pain, but it is not recommended as a first-line oral analgesic. In this case the treating physician has prescribed this compounded medication that includes Tramadol as a first line oral analgesic for an acute injury which is not supported by the MTUS Guidelines. Therefore, Synapryn is not medically necessary.

Tabradol: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63-66.

Decision rationale: The patient presents with pain affecting the head, neck, bilateral shoulders, bilateral wrists, mid back, low back, right knee and right ankle. The current request is for Tabradol. In review of the treating physician report dated 6/23/14, the provider states, "Tabradol contains cyclobenzaprine, methylsulfonymethane and other proprietary ingredients. Though methylsulfonymethane is regarded as a dietary supplement and is regulated by the FDA, it has not been approved for the treatment of osteoarthritis." The MTUS Guidelines support the usage of Cyclobenzaprine for a short course of therapy, not longer than 2-3 weeks. The provider in this case has not documented that this medication will be used for 2-3 weeks. The provider also did not document the frequency and duration of this prescription thus rendering it invalid. As such, Tabradol is not medically necessary.

Cyclobenzaprine: Upheld

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

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

Decision rationale: The patient presents with pain affecting the head, neck, bilateral shoulders, bilateral wrists, mid back, low back, right knee and right ankle. The current request is for Cyclobenzaprine. The treating physician states, "Cyclobenzaprine contains cyclobenzaprine hydrochloride and other proprietary ingredients. Cyclobenzaprine topical gel is used as a second line treatment." The MTUS Guidelines support the usage of Cyclobenzaprine (Flexeril) for a short course of therapy, not longer than 2-3 weeks. MTUS is very specific that Cyclobenzaprine is only to be used for a short course of treatment and there is no documentation from the provider as to what dosage or duration this request is for. Furthermore, if this request is for a topical gel as the provider discussed in his report, MTUS does not support muscle relaxants as a topical product. As such, Cyclobenzaprine is not medically necessary.

Terocin Patches: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic Page(s): 56-57 and 111-113.

Decision rationale: The patient presents with pain affecting the head, neck, bilateral shoulders, bilateral wrists, mid back, low back, right knee and right ankle. The current request is for Terocin Patches. The treating physician report states, "Terocine Patches for pain relief are requested for the patient." Terocin is a compounded medication, which includes Lidocaine, Capsaisin, Salicylates and Menthol. The MTUS Guidelines state: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." The MTUS Guidelines do not support the usage of salicylate topical, an NSAID for the treatment of lower back pain. Salicylate topical is supported for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. This patient presents with sprain/strain injuries affecting the neck, shoulders, wrists, thoracic, lumbar, right knee and right ankle and there is no diagnosis of osteoarthritis or tendinitis. Furthermore the provider did not document the dosage, frequency or duration for this prescription so the prescription is not valid. Therefore, Terocin Patches is not medically necessary.

Ketoprofen Cream: Upheld

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

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

Decision rationale: The patient presents with pain affecting the head, neck, bilateral shoulders and bilateral wrists, mid back, low back, right knee and right ankle. The current request is for Ketoprofen Cream. The treating physician states, "Topical NSAIDs such as Ketoprofen have been widely accepted by the medical community and have been used in Europe for over 10 years." There is no documentation of the dosage, frequency or duration of this prescription. MTUS Guidelines support use of NSAID topicals for peripheral arthritis and tendonitis. In this case the treating physician has not diagnosed the patient with arthritis or tendinitis and the provider has failed to document the dosage, frequency or duration of usage for this medication. Therefore, Ketoprofen Cream is not medically.

TENS Unit with supplies: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS (Transcutaneous Electrical Nerve Stimulation) Page(s): 114-116.

Decision rationale: The patient presents with pain affecting the head, neck, bilateral shoulders and bilateral wrists, mid back, low back, right knee and right ankle. The current request is for TENS Unit with supplies. The treating physician report dated 6/23/14 states, "a TENS unit with supplies for home use and Hot/cold unit are requested for the patient." The MTUS Guidelines do support a one month trial of TENS for specific indications including neuropathic pain, Multiple Sclerosis, CRPS, Phantom pain, Spasticity pain. In this case the treating physician does not document if this request is for a one month trial or not. MTUS also states that there must be documentation of pain for at least 3 months and the current injury occurred less than 30 days ago. Therefore, TENS Unit with supplies is not medically.

Hot/Cold Therapy Unit and supplies, purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter for Continuous-Flow Cryotherapy

Decision rationale: The patient presents with pain affecting the head, neck, bilateral shoulders and bilateral wrists, mid back, low back, right knee and right ankle. The current request is for Hot/Cold Therapy Unit and supplies, purchase. The treating physician report dated 6/23/14 states, "a TENS unit with supplies for home use and Hot/cold unit are requested for the patient." The ODG Guidelines support continuous-flow cryotherapy only after surgery as an option for up

to 7 days. In this case there is no request for surgery and no recent surgery has been performed. Therefore, Hot/Cold Therapy Unit and supplies, purchase is not medically necessary.