

Case Number:	CM14-0087546		
Date Assigned:	08/01/2014	Date of Injury:	10/07/2004
Decision Date:	09/26/2014	UR Denial Date:	05/20/2014
Priority:	Standard	Application Received:	06/11/2014

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 Occupational 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 applicant is a represented [REDACTED] employee who has filed a claim for chronic pain syndrome reportedly associated with an industrial injury of October 7, 2004. Thus far, the applicant has been treated with the following: Analgesic medications; attorney representation, transfer of care to and from various providers in various specialties; various topical compounds, oral suspensions, and the like; and percutaneous neuromodulation therapy (PNT). In a Utilization Review Report dated May 28, 2014, the claims administrator denied a request for compounded Ketoprofen cream, denied a request for compounded Cyclophene cream, denied a request for Synapryn, denied a request for Tabradol, denied a request for Deprizine, denied a request for Dicopanol, denied a request for Fanatrex, denied a request for six sessions of localized intense neurostimulation therapy, and denied a request for Terocin patches. The applicant's attorney subsequently appealed. On June 3, 2014, the applicant underwent the localized intense neurostimulation therapy at issue for alleged myofascial pain. In a medicolegal evaluation of June 29, 2005, the applicant was described as no longer working. The applicant was reportedly under considerable psychological stress owing to financial constraints, it was stated. Many of the drugs at issue were endorsed via prescription form dated June 19, 2014, in which prescriptions for Synapryn, Tabradol, Deprizine, Dicopanol, and Fanatrex were issued. No clinical progress notes were seemingly attached to the same. No rationale for selection of these agents was furnished on this occasion. On July 18, 2014, the applicant reported multifocal neck, shoulder, wrist, low back, groin, knee, and bilateral ankle pain, ranging from 5-8/10. The applicant also had issues with stress, anxiety, insomnia, and depression. The attending provider stated that the applicant's blood pressure was "uncontrolled" but failed to document the same. Platelet rich plasma therapy was sought for the shoulder and the knees while the applicant was placed off of work, on total temporary disability. A topical compounded Ketoprofen cream, a topical

compounded Cyclobenzaprine Cream, Dicoprofanol, Deprizine, Fanatrex, Synapryn, and Tabradol were all apparently prescribed. In a May 27, 2007 medicolegal evaluation, the applicant complained that earlier usage of Nexium and ranitidine "afforded him little relief."

IMR ISSUES, DECISIONS AND RATIONALES

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

Compounded Ketoprofen 20% cream.120gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic topic Page(s): 111-112.

Decision rationale: As noted on page 112 of the MTUS Chronic Pain Medical Treatment Guidelines, Ketoprofen, the primary ingredient in the compound in question, is not recommended for topical compound formulation purposes. Since one or more ingredients in the compound is not recommended, the entire compound is not recommended, per page 111 of the MTUS Chronic Pain Medical Treatment Guidelines. Therefore, the request is not medically necessary.

Compounded Cyclophene 5% cream 120gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines Topical Analgesic topic Page(s): 111.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 3, page 47, oral pharmaceuticals are first-line palliative method. In this case, there is no evidence of intolerance to and/or failure of multiple classes of first-line oral pharmaceuticals so as to justify usage of what page 111 of the MTUS Chronic Pain Medical Treatment Guidelines deems "largely experimental" topical compound such as the Cyclophene compound at issue. Therefore, the request is not medically necessary.

Synapryn 10mg oral suspension 500ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine topic Page(s): 50. Decision based on Non-MTUS Citation National Library of Medicine (NLM), Synapryn Medication Guide.

Decision rationale: Synapryn, per the National Library of Medicine, is an amalgam of Tramadol and Glucosamine. However, as noted on page 50 of the MTUS Chronic Pain Medical Treatment Guidelines, Glucosamine is recommended in the treatment of pain associated with arthritis, and, in particular, knee arthritis. In this case, however, there was no mention of the applicant carrying an active diagnosis of arthritis or knee arthritis for which the Synapryn component of the compound in question would be recommended. Since one ingredient in the compound is not recommended, the entire compound is not recommended. Therefore, the request is not medically necessary.

Tabradol 1mg oral suspension 250ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics topic Page(s): 111-113. Decision based on Non-MTUS Citation National Library of Medicine (NLM), Tabradol Medication Guide.

Decision rationale: Tabradol, per the National Library of Medicine (NLM) is an amalgam of cyclobenzaprine and MSM. However, as noted on page 113 of the MTUS Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine, the primary ingredient in the compound in question, is not recommended for compound formulation purposes. Since one or more ingredients in the compound is not recommended, the entire compound is not recommended, per page 111 of the MTUS Chronic Pain Medical Treatment Guidelines. Therefore, the request is not medically necessary.

Deprizine 15mg 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 NSAIDs, GI Symptoms, and Cardiovascular Risk topic Page(s): 59, 7.

Decision rationale: While page 59 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that ranitidine, an H2 antagonist, is indicated to treat issues of gastroesophageal reflux disease, this recommendation is qualified by commentary made on page 7 of the MTUS Chronic Pain Medical Treatment Guidelines to the effect that an attending provider should incorporate some discussion of medication efficacy into his choice of recommendations. The applicant's medicolegal evaluator earlier reported on March 27, 2007 that ranitidine had "afforded him little relief." Ongoing usage of previously tried and failed medications are not indicated. Therefore, the request is not medically necessary.

Dicopanol 5mg oral suspension 150ml: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness and Stress.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Library of Medicine (NLM), Dicopanol Medication Guide.

Decision rationale: The MTUS does not address the topic. As noted by the National Library of Medicine (NLM), Dicopanol or diphenhydramine is indicated in the treatment of allergic reactions, motion sickness, and/or parkinsonism. In this case, the attending provider's documentation made no mention of any active issues with parkinsonism, motion sickness, allergic reactions, etc., which would support provision of Dicopanol (Diphenhydramine). Therefore, the request is not medically necessary.

Fanatrex 25mg oral suspension 420ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin section Page(s): 19. Decision based on Non-MTUS Citation National Library of Medicine (NLM), Fanatrex Medication Guide.

Decision rationale: The request in question seemingly represents the renewal request for Fanatrex (Gabapentin). However, as noted on page 19 of the MTUS Chronic Pain Medical Treatment Guidelines, the applicants on Gabapentin should be asked "at each visit" as to whether there have been improvements in pain and/or function with the same. In this case, however, the attending provider has failed to quantify any decrement in pain or improvement in function achieved as a result of ongoing Gabapentin (Fanatrex) usage. The fact that the applicant is off of work, on total temporary disability, moreover, suggests a lack of functional improvement as defined in MTUS 9792.20f, despite ongoing usage of the same. Therefore, the request is not medically necessary.

6 sessions of localized intense neuro stimulation therapy for the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Lumbar & Thoracic (acute & chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percutaneous Neuromodulation Therapy (PNT) topic Page(s): 98.

Decision rationale: Based on the attending provider's description of what transpired on a procedure note of June 3, 2014, the request for localized intense neurostimulator therapy appears to represent a form of percutaneous neuromodulation therapy (PNT). However, as noted on page

98 of the MTUS Chronic Pain Medical Treatment Guidelines, percutaneous neuromodulation therapy or PNT is "not recommended" and is deemed investigational. No rationale for selection of this particular modality in the face of the unfavorable MTUS position on the same was proffered by the attending provider. Therefore, the request is not medically necessary.

Terocin Patches.: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines Topical Analgesics topic Page(s): 111.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 3, page 47, oral pharmaceuticals are first line palliative method. In this case, there is no evidence of intolerance to and/or failure of multiple classes of first line oral pharmaceuticals so as to justify usage of what page 111 of the MTUS Chronic Pain Medical Treatment Guidelines deems "largely experimental" topical compound such as the Terocin patch at issue. Therefore, the request is not medically necessary.