

Case Number:	CM15-0124981		
Date Assigned:	07/09/2015	Date of Injury:	02/09/2015
Decision Date:	09/16/2015	UR Denial Date:	06/11/2015
Priority:	Standard	Application Received:	06/29/2015

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: New York

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 39 year old male injured worker suffered an industrial injury on 2/09/2015. The diagnoses included cervical/ thoracic/ bilateral shoulder sprain/strain, rule out cervical radiculopathy, right elbow tendinosis, left elbow stain/sprain, lumbar disc displacement, discogenic spondylosis, facet arthrosis and radiculopathy. The injured worker had been treated with medications, acupuncture, chiropractic therapy, and shock wave therapy and activity restrictions. On 5/28/2015, the treating provider reported complaints of burning, radicular neck pain with muscle spasms. The pain was described as frequent to constant and moderate to severe rated 6 to 7/10. There was associated numbness and tingling in the bilateral upper extremities. She complained of burning bilateral shoulder and bilateral elbow pain. There was burning radicular mid back and with muscle spasms rated 7/10. There was burning radicular low back pain with muscle spasms rated 6 to 7/10. The injured worker reported the medications do offer temporary relief of pain an improved his ability to have a restful sleep. On exam, there was cervical tenderness with reduced range of motion. The bilateral shoulders and elbows had tenderness with reduced range of motion. The thoracic and lumbar spine had reduced range of motion and tenderness. The injured worker had/ not returned to work. The treatment plan included Synapryn, Deprizine, Dicopanol, Tabradol, Fanatrex, Ketoprofen, and Cyclobenzaprine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Synapryn 500ml: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation
<http://www.bioportfolio.com/resources/drug/22213/Synapryn.html>.

Decision rationale: Synapryn is a compounded substance that includes Tramadol as a primary ingredient and typically glucosamine as a second ingredient. While Tramadol is discussed in CA MTUS, this compounded formulation is not. ODG is also silent on this substance. Tramadol is a synthetic opioid that is typically prescribed for as needed dosing for pain control. The indications specific to Tramadol are not apparent in chart documentation. The dosing, frequency and effects are not stated. Opioid medication is not supported for use in chronic back pain. The other component, glucosamine, is recommended as an option for the treatment of moderate arthritic pain, mainly the knees. The IW does not have an active diagnosis of arthritis. The combination of these medications is not supported as one is intended for as needed breakthrough pain and carries substantial medical risks due to its potential accumulative effect. The other is for moderate pain caused by osteoarthritis and is used more liberally without the same toxicologic profile. The combination preparation is not supported and therefore, is not medically necessary.

Deprizine 250ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID, GI symptoms Page(s): 68-71.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines recommend with precautions the use of Proton Pump Inhibitor medications (PPI) for treatment of gastrointestinal symptoms related to the use of non-steroidal anti-inflammatory drug (NSAID). The documentation provided did not include any risk factors that require the use of Proton Pump Inhibitors (PPI) as there was no use of any oral NSAID use. Deprizine contained Ranitidine (H2 Blocker) along with other unknown proprietary ingredients. The guidelines do not reference the use for the class of medications called H2 blockers (histamine H2 receptor blocker) for gastrointestinal protection or prophylactic use for oral NSAID administration. The medical record did not include any gastrointestinal symptoms or use of any oral NSAID. There were no indications for the use of a suspension. Therefore, Deprizine is not medically necessary.

Dicopanorol 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 (ODG), Insomnia.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/pro/dicopanl.html>.

Decision rationale: CA MTUS and ODG are silent on this topic. Dicopanl is a combination of antihistamine and other proprietary ingredients. Unknown components of a medication cannot be evaluated to determine their safety or medical necessity. As such, the request for Dicopanl is not medically necessary. There was no indication for the use of a suspension. Therefore, Dicopanl is not medically necessary.

Tabradol 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 Muscle relaxants, Cyclobenzaprine Page(s): 63-65.

Decision rationale: Tabradol is cyclobenzaprine in an oral suspension. The CA MTUS for Chronic Pain does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short term exacerbations of chronic low back pain. This patient has chronic pain with no evidence of prescribing for flare-ups, and the pain is in the extremity, not the low back. The MTUS states that treatment with cyclobenzaprine should be brief, and that the addition of cyclobenzaprine to other agents is not recommended. In this case, cyclobenzaprine is added to other agents and the oral suspension form plus topical is experimental and unproven. Prescribing was not for a short term exacerbation. Multiple medications, including a topical muscle relaxant, were prescribed together without adequate trials of each. Per the MTUS, cyclobenzaprine is not indicated and is not medically necessary.

Fanatrex 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 AED (antiepileptic drugs) Page(s): 16-22.

Decision rationale: According to the above reference, Fanatrex is a combination of gabapentin and other proprietary ingredients. Unknown components of a medication cannot be evaluated to determine their safety or medical necessity. According to CA MTUS, topical gabapentin is not recommended as there is no peer reviewed literature to support its use. As such, the request for Fanatrex is not medically necessary.

Ketoprofen 165gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines for topical analgesics, non-steroidal anti-inflammatory drugs (NSAID) only recommend FDA approved Voltaren gel for relief of osteoarthritis pain in joints that lend themselves for treatment of the spine, hip or shoulder. According to these guidelines, Ketoprofen is not currently FDA approved for topical application. This medication is known to have high incidence of photo-contact dermatitis. As this medication is not supported by the guidelines or FDA approved, the request is not medically necessary.

Cyclobenzaprine 100gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics; Cyclobenzaprine (Flexeril). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesic, muscle relaxants Page(s): 111-113.

Decision rationale: CA MTUS chronic pain guidelines, topical analgesics are "largely experimental in use with few randomized controlled trials to determine efficacy or safety." Guidelines also state "Many agents are compounded as monotherapy or in combination for pain control... There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug that is not recommended is not recommended." CA MTUS guidelines states that cyclobenzaprine and other muscle relaxants are not recommended as there is no evidence to support its use. Additionally, the request does not include dosing frequency or duration. The request is not medically necessary.