

<b>Case Number:</b>	CM15-0129226		
<b>Date Assigned:</b>	07/22/2015	<b>Date of Injury:</b>	12/06/1990
<b>Decision Date:</b>	09/16/2015	<b>UR Denial Date:</b>	06/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/03/2015

### 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: Anesthesiology

### 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 a 62 year old male, who sustained an industrial injury on 12/6/1990. He reported being up on a ladder, then falling, resulting in injury to the head, neck, right wrist and low back. The injured worker was diagnosed as having headaches, cervical spine sprain and strain, rule out cervical radiculopathy, history of right wrist surgery, right wrist sprain and strain rule out carpal tunnel syndrome, low back pain, status post lumbar spine surgery, rule out lumbar radiculopathy, and hypertension. Treatment to date has included medications, x-rays, magnetic resonance imaging of right wrist, lumbar spine, and cervical spine (4/7/2015), nerve tests, right wrist surgery, physical therapy, and chiropractic treatments. The request is for Ketoprofen 20% cream 165 gm.; Synapryn 10mg; Tabradol 1mg; Deprizine 15mg; Dicopanol 5mg; and Fantrex 25mg. On 3/16/2015, he complained of headaches, neck pain with radiation to the bilateral upper extremities and associated numbness and tingling of the upper extremities, right wrist pain with weakness, numbness, and tingling, low back pain with radiation into the lower extremities and associated numbness and tingling of the bilateral lower extremities. He rated his low back pain 7/10, right wrist pain rated 4/10, and neck pain rated 7/10. The treatment plan included: the requested medications, x-rays of the right wrist, neck and low back, TENS unit, hot and cold unit, physical therapy, chiropractic therapy, shockwave therapy, functional capacity evaluation, magnetic resonance imaging of the right wrist, neck and low back, electrodiagnostic studies, neurostimulation therapy, and Terocin patches. On 6/15/2015, he complained of headaches, neck pain, right wrist pain, and low back pain. He rated his neck pain 6/10, right wrist pain 6/10, and low back pain 6/10. He continued with radiating pain into the bilateral upper and lower extremities. The treatment plan included: acupuncture, continue physical therapy, and continue

shockwave therapy, lumbar spine brace, and the requested medications. The records indicated his pain to be aggravated by activities of daily living including getting dressed and performing personal hygiene. He remains off work.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Ketoprofen 20% cream 165gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory agents (NSAIDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics; Ketoprofen; MTUS (2009), 9792.20; Functional restoration approach to chronic pain management Page(s): 111-113.

**Decision rationale:** According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, local anesthetics or antidepressants. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case, there is no documentation of intolerance to other previous oral medications. Ketoprofen is not currently FDA approved for a topical application, and has an extremely high incidence of photo-contact dermatitis. Medical necessity for the requested topical Ketoprofen cream has not been established. The requested topical cream is not medically necessary.

**Synapryn 10mg (unspecified quantity):** 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 Opioids for the treatment of chronic pain Page(s): 93-96.

**Decision rationale:** According to the California MTUS, Synapryn oral suspension (Tramadol hydrochloride with glucosamine) contains a synthetic opioid, which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. According to the medical records, there has been no documentation of the medication's analgesic effectiveness or functional improvement, and no clear documentation that the patient has responded to ongoing opioid therapy. Evidence-based guidelines and peer-reviewed medical literature do not address the use of medications in oral suspension form. In addition, there is no request for a specified quantity of medication in this case. Medical necessity for the requested Synapryn 10mg/ml oral suspension has not been established. Of note, discontinuation of an opioid analgesic requires a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

**Tabradol 1mg (unspecified quantity): 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 Page(s): 63.

**Decision rationale:** According to the reviewed literature, Tabradol (Cyclobenzaprine) oral suspension is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. In this case, there are no muscle spasms documented on physical exam. There is no documentation of functional improvement from any previous use of this medication. Tabradol oral suspension is a suspension consisting of un-dissolved particles of one or more medicinal agents mixed with a liquid vehicle for oral administration. Evidence-based guidelines and peer-reviewed medical literature do not address the use of medications in oral suspension form. In addition, there is no request for a specified quantity of medication in this case. Based on the currently available information, the medical necessity for Tabradol 1mg/ml oral suspension has not been established. The requested medication is not medically necessary.

**Deprizine 15mg (unspecified quantity): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Up-To-Date.

**Decision rationale:** Deprizine (Ranitidine) oral suspension is a histamine blocker and antacid used to treat peptic ulcers, gastritis and gastro-esophageal reflux (GERD). Ranitidine works by blocking the effects of histamine on the receptor site known as H2. Proton Pump Inhibitors (PPI's) are prescribed to prevent and treat ulcers in the duodenum (where most ulcers develop) and the stomach. Deprizine oral suspension is a suspension consisting of un-dissolved particles of one or more medicinal agents mixed with a liquid vehicle for oral administration. In this case, there is no documentation to support the injured worker had a gastrointestinal disorder, peptic ulcer or gastroesophageal reflux disease. In addition, there is no request for a specified quantity of medication. Medical necessity of the Deprizine oral suspension has not been established. The requested medication is not medically necessary.

**Dicopanol 5mg (unspecified quantity): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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, Sedative-hypnotics, Benadryl - diphenhydramine.

**Decision rationale:** Dicopanol, the oral suspension form of Diphenhydramine, is an antihistamine that is used for the temporary relief of seasonal and perennial allergy symptoms. The medication is sedating and has been used for short-term treatment of insomnia. Antihistamines are not indicated for long term use as tolerance develops quickly. There is no documentation indicating the patient has any history of insomnia. The MTUS does not address the use of hypnotics other than benzodiazepines. Treatment of a sleep disorder, including prescribing hypnotics, should not be initiated without a careful diagnosis. There is no evidence of this in this case. In addition, there is no documentation of a specified quantity of medication requested. Medical necessity for the requested oral suspension medication has not been established. The requested medication is not medically necessary.

**Fanatrex 25mg (unspecified quantity):** 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 AEDs anti-epilepsy drugs Page(s): 16-22.

**Decision rationale:** According to the CA MTUS and ODG, Fanatrex Oral Suspension (Gabapentin) is an anti-epilepsy drug (AED), which has been considered a first-line treatment for neuropathic pain. In this case, there is no documentation indicating the patient has neuropathic pain. In addition, there are no physician reports, which adequately address the specific symptomatic and functional benefit from the AEDs used to date. Note the criteria for a "good" response per the MTUS. Medical necessity for the requested medication, Fanatrex oral suspension, has not been established. The requested medication is not medically necessary.