

Case Number:	CM15-0138905		
Date Assigned:	09/10/2015	Date of Injury:	01/17/2014
Decision Date:	12/14/2015	UR Denial Date:	06/20/2015
Priority:	Standard	Application Received:	07/17/2015

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: Tennessee, Florida, Ohio
 Certification(s)/Specialty: Surgery, Surgical Critical Care

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 63 year old male, who sustained an industrial injury on 1-17-2014. Medical records indicate the worker is undergoing treatment for left shoulder and elbow sprain-strain, bilateral knee and ankle sprain-strain and lumbar sprain-strain. A recent progress report dated 5-12-2015, reported the injured worker complained of pain in the left shoulder, lower back, left elbow and left knee rated 6-7 out of 10 and pain in the right knee ankle and foot rated 4-6 out of 10. Physical examination revealed left elbow and shoulder tenderness, lumbar tenderness, bilateral knee and ankle tenderness and right foot tenderness. Left shoulder magnetic resonance imaging showed partial thickness tear of the supraspinatus tendon, acromioclavicular osteoarthritis and impingement. Right ankle magnetic resonance imaging showed tenosynovitis and right foot magnetic resonance imaging showed mild osteoarthrosis. Left ankle magnetic resonance imaging showed tenosynovitis. Left elbow magnetic resonance imaging showed partial thickness tearing and tendinosis. Lumbar magnetic resonance imaging showed disc protrusions and herniation. Magnetic resonance imaging of the right knee a possible internal derangement and magnetic resonance imaging of the left knee showed anterior cruciate ligament and medial meniscus tears. Treatment to date has included physical therapy and medication management. The physician is requesting Deprizine suspension 15gm per ml, Compound HMP HCC 240 grams, Fanatrex suspension 25mg per ml 420 ml, Compound HNPC1 240 gms, Ketoprofen cream 20%, Cyclobenzaprine cream 5% and Synapryn oral suspension 10mg per ml 500 ml. On 6-18-2015, the Utilization Review noncertified the request for Deprizine suspension 15gm per ml, Compound HMP HCC 240 grams, Fanatrex suspension 25mg per ml 420 ml,

Compound HNPC1 240 gms, Ketoprofen cream 20%, Cyclobenzaprine cream 5% and Synapryn oral suspension 10mg per ml 500 ml.

IMR ISSUES, DECISIONS AND RATIONALES

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

Deprizine suspension 15gm/ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. The MTUS Chronic Pain Medical Treatment Guidelines note that H2 antagonists such as ranitidine (Deprizine) are indicated in the treatment of NSAID-induced dyspepsia. In this case, however, there was no mention of the applicant having any issues with reflux, heartburn, and/or dyspepsia, either NSAID-induced or stand-alone, on or around the date in question. Therefore, based on the submitted medical documentation, the request for deprizine is not medically necessary.

Compound HMP HCC 240 grams: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this medication for this patient. Per the California MTUS Chronic Pain guidelines, topical analgesics are not recommended as an option for chronic pain control and are largely experimental in use with few randomized control trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended as a whole. The requested cream is a combination of multiple medications. Compounded medications are not FDA approved or recommended by ODG guidelines due to concerns of purity and efficacy. Hence, the request for this compounded medication is not appropriate or indicated by MTUS and ODG guidelines. Therefore, based on the submitted medical documentation, the request for HMP HCC is not medically necessary.

Fanatrex suspension 25mg/ml 420ml: 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).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. Page 49 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that gabapentin is indicated in the treatment of localized peripheral pain or neuropathic pain as was/is present here in the form of the applicant's digital paresthesias. This recommendation is, however, qualified by commentary made on page 47 of the ACOEM Practice Guidelines and on page 7 of the MTUS Chronic Pain Medical Treatment Guidelines to the effect that an attending provider should incorporate some discussion of "cost" into his choice of pharmacotherapy. Here, the attending provider did not clearly outline why a custom compounded, brand-name Fanatrex agent was being employed in favor of generic gabapentin. The attending provider, thus, did not incorporate any discussion of cost into his choice of pharmacotherapy. Therefore, based on the submitted medical documentation, the request for fanatrex is not medically necessary.

Compound HNPC1 240 grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this medication for this patient. Per the California MTUS Chronic Pain guidelines, topical analgesics are not recommended as an option for chronic pain control and are largely experimental in use with few randomized control trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended as a whole. The requested cream is a combination of multiple medications. Compounded medications are not FDA approved or recommended by ODG guidelines due to concerns of purity and efficacy. Hence, the request for this compounded medication is not appropriate or indicated by MTUS and ODG guidelines. Therefore, based on the submitted medical documentation, the request for HNPC1 is not medically necessary.

Ketoprofen cream 20%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of treatment of Ketoprofen ointment for this patient. The California MTUS guidelines address the topic of NSAID prescriptions by stating, "A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more

effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics." Furthermore, MTUS guidelines specifically state regarding topical Non-steroidal antiinflammatory agents (NSAIDs): "The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period." Compounded medications are not subject to FDA oversight for purity or efficacy. The medical records do not support that the patient has osteoarthritis or a contraindication to other non-opioid analgesics. Therefore, based on the submitted medical documentation, the request for Ketoprofen ointment prescription is not medically necessary.

Cyclobenzaprine cream 5%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril).

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. In accordance with the California MTUS guidelines, Cyclobenzaprine is a muscle relaxant and muscle relaxants are not recommended for the treatment of chronic pain. From the MTUS guidelines: "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic back pain. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence." This patient has been diagnosed with chronic back pain of the cervical and upper spine. Per MTUS, the use of a muscle relaxant is not indicated. Therefore, based on the submitted medical documentation, the request for Cyclobenzaprine cream is not medically necessary.

Synapryn oral suspension 10mg/1ml 500ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation <http://dailymed.nlm.nih.gov/dailymed/archives/fdadrginfo.cfm?archiveid=22416>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Glucosamine (and Chondroitin Sulfate).

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. Synapryn, per the National Library of Medicine (NLM), is an amalgam of tramadol and glucosamine. Page 50 of the MTUS Chronic Pain Medical Treatment Guidelines notes that glucosamine is indicated in the treatment of arthritis and, in particular, that associated with knee arthritis. In this case, however, there was no mention of the

applicant having any issues with either arthritis and/or knee arthritis for which usage of glucosamine would have been indicated. Since the glucosamine ingredient in the Synapryn amalgam is not recommended, the entire amalgam is not recommended. Therefore, based on the submitted medical documentation, the request for synapryn is not medically necessary.