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| Case Number: | CM15-0023165 | | |
| Date Assigned: | 02/12/2015 | Date of Injury: | 03/27/2007 |
| Decision Date: | 04/01/2015 | UR Denial Date: | 01/09/2015 |
| Priority: | Standard | Application Received: | 02/06/2015 |

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:

This is a 49 year-old female who has reported widespread pain after an injury on 3/27/07. The ongoing diagnoses include cervical degenerative disc disease, radiculopathy, shoulder tendinitis, osteoarthritis, bursitis, lumbago, and a knee contusion. Treatments have included medications, carpal tunnel surgery. Reports from the current primary treating physician during 2014 to January 2015 are of widespread pain. Unspecified medications are reported to help pain and sleep. There are no reports which discuss the specific results of using any medication or which discuss the patient-specific indications for any medication. The current medications appear to have been prescribed since at least August 2014. Per the PR2 of 12/5/14, there were symptoms in the neck, all extremities, low back, shoulders, and knees. There was no discussion of the patient-specific indications and results for any of the medications. The injured worker remained temporary total disabled. On 1/9/15 Utilization Review non-certified the medications now under Independent Medical Review. Note was made of the lack of indications and lack of compliance with guidelines. The MTUS and the Official Disability Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tabradol 1mg/ML 5 ML 2-3 x per day qty: 250 ML date of service 12/5/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation
<http://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=22434>.

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

Decision rationale: Tabradol is cyclobenzaprine in an oral suspension. The 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.

Synapryn 10mg/ML 5 ML 3x day as directed for pain qty 500ml date of service 12/5/14:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation
<http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?id=20039>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids; Glucosamine (and Chondroitin Sulfate) Page(s): 77-80; 50.

Decision rationale: Synapryn is tramadol with glucosamine in an oral suspension: The reason for combining these medications is not discussed in any physician report. Given that tramadol is generally an as needed medication to be used as little as possible, and that glucosamine is to be taken regularly regardless of acute symptoms, the combination product is illogical and not indicated. Tramadol is prescribed without clear evidence of the considerations and expectations found in the MTUS and similar guidelines. Opioids are minimally indicated, if at all, for chronic back pain. The prescribing physician does not specifically address function with respect to prescribing opioids, and does not address the other recommendations in the MTUS. There is no evidence that the treating physician has utilized a treatment plan not using opioids, and that the patient has failed a trial of non-opioid analgesics. The MTUS provides support for treating moderate arthritis pain, particularly knee OA, with glucosamine sulphate. Other forms of glucosamine are not supported by good medical evidence. The treating physician in this case has not provided evidence of the form of glucosamine in Synapryn, and that it is the form recommended in the MTUS and supported by the best medical evidence. And should there be any indication for glucosamine in this case, it must be given as a single agent apart from other analgesics, particularly analgesics like tramadol which are habituating. Synapryn is not medically necessary based on the MTUS, lack of good medical evidence, and lack of a treatment plan for chronic opioid therapy consistent with the MTUS.

Fanatrex 25mg/ML 5 ML TID for chronic Neuropathic pain qty 420 ML date of service 12/5/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000704/>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs Page(s): 16-21.

Decision rationale: Fanatrex is stated to be a formulation of gabapentin. The treating physician has stated that it is for neuropathic pain. None of the physician reports adequately discuss the signs and symptoms diagnostic of neuropathic pain. There are no physician reports which adequately address the specific symptomatic and functional benefit from the anti-epilepsy drugs used to date. MTUS outlines specific criteria for a good or moderate response. Reports indicated a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the trigger for the following 1) switch to a different first-line agent or 2) combination therapy. Chart documentation does not discuss specific response to this medication. Gabapentin is not medically necessary based on the lack of any clear indication, and the lack of significant symptomatic and functional benefit from its use to date.

Ketoprofen 20% cream 165 gms date of service 12/5/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

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

Decision rationale: The request does not contain directions for use. Per the MTUS, topical NSAIDs are only for use on the extremities and only for short durations. It is not clear in this case that use is for the extremities only. Use to date has been long term. Note that topical ketoprofen is not FDA approved, and is not recommended per the MTUS citation above. This topical agent is not medically necessary based on the MTUS.

Deprizine 15mg/ML 10ml daily for GI pain qty 250 ML date of service 12/5/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000094/>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 69.

Decision rationale: Deprizine is ranitidine in an oral suspension. Ranitidine is prescribed without any patient-specific rationale provided. If ranitidine is prescribed as cotherapy with an NSAID, ranitidine is not the best drug. Note the MTUS recommendations cited. There are no medical reports which adequately describe the relevant signs and symptoms of possible GI disease. There is no examination of the abdomen on record. There are many possible etiologies for GI symptoms; the available reports do not provide adequate consideration of these possibilities. Empiric treatment after minimal evaluation is not indicated. Cotherapy with an NSAID is not indicated in patients other than those at high risk. No reports describe the specific risk factors present in this case. Ranitidine is not medically necessary based on the MTUS.

Dicopanol 5mg/ML 1 ML at bedtime for insomnia qty 150 ML date of service 12/5/14:

Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/pro/dicopanol.html>, <http://www.drugs.com/pro/diphenhydramine.html#ixzz0xZifcbWP>.

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

Decision rationale: The treating physician has stated that Dicopanol is diphenhydramine and other unnamed ingredients. Medical necessity cannot be determined for unspecified compounds, and unpublished ingredients cannot be assumed to be safe or effective. Dicopanol is not medically necessary on this basis alone. In addition, Dicopanol is stated to be for insomnia. The MTUS does not address the use of hypnotics other than benzodiazepines. No physician reports describe the specific criteria for a sleep disorder. Treatment of a sleep disorder, including prescribing hypnotics, should not be initiated without a careful diagnosis. There is no evidence of that in this case. Note the Official Disability Guidelines citation above. That citation also states that antihistamines are not indicated for long term use as tolerance develops quickly, and that there are many, significant side effects. Dicopanol is not medically necessary based on lack of a sufficient analysis of the patient's condition, the ODG citation, and lack of information provided about the ingredients.

Cyclobenzaprine 5% cream 100gms qty 1 date of service 12/5/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112-113.

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

Decision rationale: Per the MTUS citation above, there is no good evidence in support of topical muscle relaxants. These agents are not recommended. In addition, two muscle relaxants were dispensed simultaneously (two forms of cyclobenzaprine), which is duplicative,

unnecessary, and potentially toxic. This topical agent is not medically necessary based on the MTUS.