

<b>Case Number:</b>	CM15-0044084		
<b>Date Assigned:</b>	04/13/2015	<b>Date of Injury:</b>	11/01/2011
<b>Decision Date:</b>	05/28/2015	<b>UR Denial Date:</b>	02/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/09/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 39 year old male who sustained a work related injury on 11/01/2011. The diagnoses have included status post head concussion, cervical strain/sprain, cervical radiculopathy, shoulder strain/sprain, thoracic strain/sprain, low back pain, lumbar radiculitis, bilateral knee strain/sprain and bilateral ankle strain/sprain. Treatments have included acupuncture, ESWT and medications including medicated cream. In the PR-2 dated 01/21/2015, the injured worker complains of dull, achy headaches. The injured worker also noted persistent pain over multiple areas of the body with radiating pain in the bilateral upper and lower extremities as well as palpable muscle spasm. Medications offered temporary relief and improved the ability to have a restful sleep. Upon examination of the cervical spine, there was 2+ tenderness at the suboccipital region as well as over both scalene and trapezius muscles. There was limited cervical range of motion, positive maximum foraminal compression tests, and positive cervical distraction tests. There was tenderness at the deltopectoral groove and insertion site of the supraspinatus muscle. Limited range of motion of the bilateral shoulders was noted as well as positive supraspinatus testing. Sensation to pinprick and light touch was slightly diminished over the C5-T1 dermatomes. Motor strength was 4/5 in the bilateral upper extremities. There was 2+ tenderness over the thoracic and lumbar spine paraspinal muscles, limited range of motion of the thoracic and lumbar spine, spasm in the lumbar paraspinal muscles, 2+ tenderness over the trochanteric bursa, slightly limited flexion of the bilateral hips, a positive Patrick's test, tenderness over the medial and lateral joint line of the bilateral knees, limited range of motion of the bilateral knees, a positive Lachman's test bilaterally, a positive

McMurray's test bilaterally, tenderness at the medial and lateral malleolus and over the anterior talofibular ligament, limited range of motion of the bilateral ankles, positive anterior and posterior drawer tests, and decreased sensation to pinprick and light touch in the L4-S1 dermatomes. Treatment recommendations included an MRI of the cervical and lumbar spine, electrodiagnostic studies, and continuation of the current medication regimen. A Request for Authorization form was submitted on 01/21/2015.

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

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

**Topical compound: Ketoprofen 20% cream 167grams: Upheld**

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

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

**Decision rationale:** The California MTUS Guidelines state any compounded product that contains at least 1 drug that is not recommended, is not recommended as a whole. The only FDA approved topical NSAID is diclofenac. The request for a compounded cream containing ketoprofen would not be supported. There is also no frequency listed in the request. As such, the request is not medically necessary.

**Topical compound: Cyclobenzaprine 5% cream 110 grams: Upheld**

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

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

**Decision rationale:** The California MTUS Guidelines state any compounded product that contains at least 1 drug that is not recommended, is not recommended as a whole. Muscle relaxants are not recommended for topical use. The request for a compounded cream containing cyclobenzaprine would not be supported. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

**Synapryn 10mg/1ml oral suspension 500ml: 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 Page(s): 74-82.

**Decision rationale:** The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the clinical notes submitted, there was no evidence of a failure of non-opioid analgesics. The injured worker has utilized the above medication since at least 08/2014 without any evidence of significant functional improvement. Additionally, there is no indication that this injured worker is unable to swallow pills or capsules. Given the above, the request is not medically appropriate.

**Tabradol 1ml/1ml oral suspension 250mg:** 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 Page(s): 63-66.

**Decision rationale:** The California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations in patients with chronic low back pain. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. The injured worker has utilized the above medication since at least 08/2014 without any evidence of significant functional improvement. Additionally, there is no indication that this injured worker is unable to swallow pills or capsules. Given the above, the request is not medically appropriate.

**Deprizine 15mg/ml 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 Page(s): 68-69.

**Decision rationale:** The California MTUS Guidelines state proton pump inhibitors are recommended for patients with intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor. There is no evidence of cardiovascular disease or increased risk factors for gastrointestinal events. Additionally, there is no indication that this injured worker is unable to swallow pills or capsules. Given the above, the request is not medically appropriate.

**Dicopanol (Diphenhydramine) 5ml/ml 150ml:** 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) Chronic Pain Chapter, Insomnia Treatment.

**Decision rationale:** The Official Disability Guidelines state diphenhydramine is a sedating antihistamine, often utilized as an over-the-counter medication for insomnia treatment. As per the clinical notes submitted, there is no indication of chronic insomnia or a chronic condition where an antihistamine is necessary. There is also no indication that this injured worker cannot safely swallow pills or capsules. The medical necessity has not been established. As such, the request is not medically appropriate.

**Fanax (Gabapentin) 25ml/ml 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 Page(s): 16-19.

**Decision rationale:** The California MTUS Guidelines state anti-epilepsy drugs are recommended for neuropathic pain. Gabapentin is recommended for treatment of diabetic painful neuropathy and post-herpetic neuralgia. It is also considered first line treatment for neuropathic pain. The injured worker has utilized the above medication since at least 08/2014 without any evidence of significant functional improvement. The medical necessity for gabapentin with other proprietary ingredients has not been established. Additionally, there is no indication that this injured worker is unable to swallow pills or capsules. Given the above, the request is not medically appropriate.

**MRI of the cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state for most patients presenting with true neck and upper back problems, special studies are not needed unless a 3 to 4 week period of conservative care and observation fails to improve symptoms. The injured worker is pending a course of shockwave therapy for the cervical and lumbar spine. There is no mention of an exhaustion of any recent conservative management prior to the request for an imaging study. There is no evidence of a progression or worsening of symptoms or examination findings. The medical necessity has not been established. Therefore, the request is not medically necessary.