

Case Number:	CM15-0071601		
Date Assigned:	04/22/2015	Date of Injury:	09/10/2013
Decision Date:	05/22/2015	UR Denial Date:	03/12/2015
Priority:	Standard	Application Received:	04/14/2015

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 injured worker is a 59-year-old male who sustained an industrial injury on 9/10/13. The injured worker reported symptoms in the neck, shoulders and back. The injured worker was diagnosed as having cervical intervertebral disc syndrome, thoracic sprain/strain and right shoulder sprain/strain. Treatments to date have included oral and topical non-steroidal anti-inflammatory drugs and oral pain medication. Evaluation dated 2/18/2015 indicates patient reported pain in the neck , mid-upper back and right shoulder. Exam findings document right shoulder pain, decreased shoulder range of motions, negative compression test bilaterally, positive depression test bilaterally, thoracic back pain with negative Kemp tests. On 3/12/15 UR non-certified request for Ketoprofen, cream, cyclobenzaprine cream, Fanatrex, Synapryn, Deprizine, Dicopanlol, and Tabradol. CA MTUS was cited in support of decisions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 20% cream #167 gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Agents Page(s): 111-112.

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." One of the included compounds in the requested medication is Gabapentin. MTUS guidelines states that ketoprofen cream is not approved by the FDA. As such, the request is not medically necessary.

Cyclobenzaprine 5% cream #110gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Agents Page(s): 111-112.

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." Cyclobenzaprine is a muscle relaxant. MTUS guidelines states that the use of topical muscle relaxants is not supported by evidence. Therefore, the request is not medically necessary.

Fanatrex 420ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Agents Page(s): 111-112. Decision based on Non-MTUS Citation <http://www.drugs.com/pro/fanatrex.html>.

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.

Synapryn 500ml: Upheld

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

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, not medically necessary.

Tabradol 250ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tabradol Page(s): 41-42.

Decision rationale: Tabradol is an oral solution of cyclobenzaprine. According to CA MTUS, this medication is recommended only for a short course of therapy. The effect is noted to be greatest in the first 4 days of treatment, therefore not supportive for use in chronic pain. Additionally, cyclobenzaprine is not recommended to be added to other agents. For all of these reasons, cyclobenzaprine is not indicated and is not medically necessary.

Deprizine 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 NSAIDS, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: Deprizine is the oral solution equivalent of ranitidine. According to CA MTUS, gastrointestinal protectant agents are recommended for patients that are at increased risk for gastrointestinal events. These risks include age >65, history or gastrointestinal bleeding or

peptic ulcers, concomitant use of NSAIDs and corticosteroids or aspirin, or high dose NSAID use. The chart does not document any of these risk factors. Past medical history does not include any gastrointestinal disorders, there is no history of poor tolerance to NSAIDs documented and there are not abdominal examinations noted in the chart. Ranitidine is not medically necessary based on the MTUS.

Dicopanol 150 ml: 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 <http://www.drugs.com/pro/dicopanol.html>.

Decision rationale: CA MTUS and ODG are silent on this medication. According to the above reference, Dicopanol 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 Dicopanol is not medically necessary.