

<b>Case Number:</b>	CM15-0092181		
<b>Date Assigned:</b>	07/14/2015	<b>Date of Injury:</b>	01/27/2014
<b>Decision Date:</b>	09/16/2015	<b>UR Denial Date:</b>	04/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/13/2015

### 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: Pediatrics, Internal 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 female who sustained an industrial injury on 01/27/2014. Current diagnoses include right wrist/hand sprain/strain, rule out right wrist internal derangement, status post right hand/wrist surgery, and status post right wrist fracture. Previous treatments included medications, surgery, physical therapy, brace, and acupuncture. Previous diagnostic studies include right hand x-rays, right wrist and right hand MRI, electrodiagnostic study, and urine toxicology screening. Initial injuries were sustained to the back and right hand when the worker slipped and fell backwards. Report dated 04/14/2015 noted that the injured worker presented with complaints that included status post right wrist surgery with residual pain with associated weakness, numbness, and tingling in the hand and fingers. Pain level was 7 out of 10 on a visual analog scale (VAS). The injured worker stated that symptoms persist but the medications do offer temporary relief of pain and improve her ability to have restful sleep. Physical examination was positive for mild swelling in the right wrist/hand, tenderness to palpation over the carpal bones and at the anatomical snuffbox, decreased range of motion, slightly diminished sensation over the C5-T1 dermatomes in the right upper extremity, and decreased motor strength secondary to pain in the right upper extremity. The treatment plan included continuing with physical therapy and acupuncture, continue with shockwave therapy for the right wrist, requests for Terocin patches, continue with pain medications which included depirizine, dicopanol, Fanatrex, Synapryn, Tabradol, cyclobenzaprine, and Ketoprofen cream, and follow up in 4 weeks. The injured worker was currently temporarily totally disabled at the time of this report. Disputed treatments include Synapryn 10mg/1ml oral suspension 500ml, Tabradol 1mg/ml oral suspension 250ml, depirizine 15mg/ml oral suspension 250ml, dicopanol (Diphenhydramine) 5mg/ml oral suspension 150ml, Fanatrex (Gabapentin) 25mg/ml oral

suspension 420ml, Capsaicin (unknown frequency & dosage), 18 Acupuncture Visits, shockwave therapy 1 course up to 3 treatments, and Menthol (unknown frequency & dosage).

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

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

#### **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 Glucosamine (and Chondroitin Sulfate), Medications for chronic pain, Opioids, Indications- Chronic back pain Page(s): 50, 60, 77-80.

**Decision rationale:** The reason for combining these medications is not discussed in any physician report. Given that Tramadol is generally a prn medication to be used as little as possible, and that glucosamine is to be taken regularly regardless of acute symptoms, the combination product 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.

#### **Tabradol 1mg/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 Medications for chronic pain, Muscle relaxants Page(s): 60, 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.

**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 NSAIDs, GI symptoms & cardiovascular risk Page(s): 69.

**Decision rationale:** Deprizine is ranitidine in an oral suspension. Ranitidine is prescribed without any 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 (Diphenhydramine) 5mg/ml oral suspension 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) 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.

**Fanatrex (Gabapentin) 25mg/ml oral suspension 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 Anti-Epilepsy Drugs, Medications for chronic pain Page(s): 16-21, 60.

**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 or diagnosis of neuropathic pain. There are no physician reports which adequately address the specific symptomatic and functional benefit from the anti-epileptic drugs (AEDs) used to date. Note the criteria for a "good" response per the MTUS. AED's have a significant risk of teratogenicity and alterations in contraceptives and this must be discussed with the patient. There is no evidence that this injured woman has been counseled regarding this significant issue. Fanatrex (gabapentin) is not medically necessary based on the lack of any clear indication, the lack of counseling and consent regarding the reproductive risks, and the lack of significant symptomatic and functional benefit from its use to date.

### **18 Acupuncture Visits: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines Functional improvement Page(s): 1.

**Decision rationale:** The California MTUS recommends "acupuncture to be used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease side effects of medications-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasms." The documentation submitted for review included 4 progress notes from prior acupuncture, there was no functional improvement documented with the use of acupuncture. Functional improvement means decrease in work restrictions or improvement in activities of daily living (ADLs) plus decreased dependence on medical treatment. The injured worker is not working, and she is seen monthly in the office. Furthermore the submitted medical records do not support that the injured worker's medications have been reduced or not tolerated. Therefore the request for 18 Acupuncture Visits is not medically necessary.

### **Shockwave Therapy 1 course up to 3 treatments: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 29.

**Decision rationale:** The MTUS guidelines state that there has been several studies evaluating the efficacy of extracorporeal shockwave therapy for the treatment of lateral epicondylitis. These studies did not demonstrate benefits for the management of lateral epicondylitis. There are no studies supporting its use for neck, shoulder, and wrist pain. The request for shockwave therapy is for the right wrist. Therefore based on the recommended guidelines, shockwave therapy for the wrist is not recommended. The request for Shockwave Therapy 1 course up to 3 treatments is not medically necessary.

### **Capsaicin (unknown frequency & dosage): 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 Capsaicin Page(s): 28-29.

**Decision rationale:** The California MTUS has specific guidelines for Capsaicin. "Capsaicin is recommended as an option in patients who have not responded or are intolerant to other treatments. The treating physician's request did not include the concentration, quantity, site of application, or directions for use. As such, the prescription is not sufficient and not medically necessary. Therefore the request for Capsaicin is not medically necessary.

**Menthol (unknown frequency & dosage):** 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 UpToDate: camphor and menthol: drug information. In UpToDate, edited by Ted. W. Post, published by UpToDate in Waltham, MA, 2015.

**Decision rationale:** The MTUS and ODG are silent with regard to menthol. It may be used for relief of dry, itchy skin. These agents carry warnings that they may cause serious burns. Also, the treating physician's request did not include the concentration, quantity, site of application, or directions for use. As such, the prescription is not sufficient and not medically necessary. Therefore the request for Menthol is not medically necessary.