

Case Number:	CM15-0120396		
Date Assigned:	06/30/2015	Date of Injury:	12/31/2012
Decision Date:	10/06/2015	UR Denial Date:	06/08/2015
Priority:	Standard	Application Received:	06/22/2015

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: 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 64-year-old male, who sustained an industrial injury on 12/31/2012. Diagnoses include headache, cervical spine pain, sprain of ligaments of cervical spine, rule out cervical disc displacement, contusion of neck, cervical radiculopathy, sprain/strain bilateral shoulder joint, joint derangement bilateral shoulder, rule out DeQuervain's tenosynovitis, sprain/strain thoracic spine, rule out thoracic intervertebral disc displacement, lumbar spine pain, sprain of ligaments lumbar spine, rule out lumbar intervertebral disc displacement, lumbar radiculopathy, mood disorder, sleep disorder and Parkinson's disease. Treatment to date has included diagnostics, medications, and shockwave therapy and activity modifications. Per the Primary Treating Physician's Progress Report dated 4/29/2015, the injured worker reported neck pain, bilateral shoulder pain, bilateral wrist and hand pain, and mid and low back pain. Physical examination of the cervical spine revealed tenderness to palpation and decreased ranges of motion in all planes. Examination of the bilateral shoulders revealed tenderness with decreased flexion, extension and abduction bilaterally. Bilateral wrist/hand examination revealed tenderness to palpation and decreased ranges of motion. Thoracic and lumbar spine examination revealed tenderness to palpation and spasms and decreased ranges of motion of the lumbar spine. The plan of care included medications and authorization was requested for Ketoprofen 20% cream, Cyclobenzaprine 5% cream, Synapryn 10mg/10mL oral suspension, Tabradol 1mg/2mL oral suspension, Deprizine 15mcg/mL oral suspension, Dicopanol 5mg/mL oral suspension, and Fanatrex 25mg/mol oral suspension.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Ketoprofen 20% cream 165gm DOS 04/29/2015: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): s 111-112.

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

Decision rationale: The request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients which each have specific properties and mechanisms of action. The MTUS guidelines state the following: Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case, the use of the topical muscle relaxant is not indicated for use for the patient's condition. The MTUS states the following: "There is no evidence for use of any other muscle relaxant as a topical product." As such, the request is not medically necessary.

Retrospective request for Cyclobenzaprine 5% cream 100gm DOS 04/29/2015: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

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

Decision rationale: The request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients which each have specific properties and mechanisms of action. The MTUS guidelines state the following: Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case, the use of the topical muscle relaxant is not indicated for use for the patient's condition. The MTUS states the following: "There is no evidence for use of any other muscle relaxant as a topical product." As such, the request is not certified

Retrospective request for Synapryn 10mg/1ml oral suspension 500ml DOS 04/29/2015: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate) Page(s): 50.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 80-83.

Decision rationale: Tramadol is a pain medication in the category of a centrally acting analgesic. They exhibit opioid activity and a mechanism of action that inhibits the reuptake of

serotonin and norepinephrine. Centrally acting drugs are reported to be effective in managing neuropathic type pain although it is not recommended as first line therapy. The side effect profile is similar to opioids. For chronic back pain, it appears to be efficacious for short term pain relief, but long term (>16 weeks) results are limited. It also did not appear to improve function. The use of tramadol for osteoarthritis is indicated for short term use only (<3 months) with poor long-term benefit. In this case, the patient does not meet the qualifying criteria. This is secondary to the duration of use, with this medication being indicated on a short-term basis only. As such, the request is not medically necessary.

Retrospective request for Tramadadol 1mg/ml oral suspension 250ml DOS 04/29/2015:

Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 93-94.

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

Decision rationale: The request is for the use of Cyclobenzapril. This medication is classified as a muscle relaxant and central nervous system depressant with side effects including drowsiness and dizziness. The MTUS guidelines states that it is indicated for short term use for low back pain. The effect seems to be greatest the first 4 days of use which suggests that treatment should be brief. In this case, due to the duration of treatment, further use would not be indicated. As such, the request would not be medically necessary.

Retrospective request for Deprizine 15mg/ml oral suspension 250ml DOS 04/29/2015:

Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): s 76-78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: The request is for the use of Dephenhydramine medication. The ODG guidelines advise the following regarding its use: Not recommended. See Insomnia treatment, where sedating antihistamines are not recommended for long-term insomnia treatment. The AGS updated Beers criteria for inappropriate medication use includes diphenhydramine. (AGS, 2012) Anticholinergic drugs, including diphenhydramine, may increase the risk for dementia by 50% in older adults. There is an obvious dose-response relationship between anticholinergic drug use and risk of developing dementia, but chronic use, even at low doses, would be in the highest risk category. While there is awareness that these drugs may cause short-term drowsiness or confusion, which is included in the prescribing information, there is no mention of long-term effects on cognition, and generally awareness of this issue is very low, and both the public and doctors need to be encouraged to use alternative treatments where possible. (Gray, 2015) As stated above, the use of this medication is not indicated. This is secondary to poor clinical evidence regarding its safe and effective use. As such, the request is not medically necessary.

**Retrospective request for Dicopanol (Diphenhydramine) 5mg/ml oral suspension 150ml
DOS 04/29/2015: Upheld**

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Online Version, Insomnia treatment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress Diphenhydramine (Benadryl).

Decision rationale: The request is for the use of Diphenhydramine medication. The ODG guidelines advise the following regarding its use: Not recommended. See Insomnia treatment, where sedating antihistamines are not recommended for long-term insomnia treatment. The AGS updated Beers criteria for inappropriate medication use includes diphenhydramine. (AGS, 2012) Anticholinergic drugs, including diphenhydramine, may increase the risk for dementia by 50% in older adults. There is an obvious dose-response relationship between anticholinergic drug use and risk of developing dementia, but chronic use, even at low doses, would be in the highest risk category. While there is awareness that these drugs may cause short-term drowsiness or confusion, which is included in the prescribing information, there is no mention of long-term effects on cognition, and generally awareness of this issue is very low, and both the public and doctors need to be encouraged to use alternative treatments where possible. (Gray, 2015) As stated above, the use of this medication is not indicated. This is secondary to poor clinical evidence regarding its safe and effective use. As such, the request is not certified.

**Retrospective request for Fanatrex (Gabapentin) 25mg/mol oral suspension 420ml DOS
04/29/2015: Upheld**

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs Page(s): 16-19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-17.

Decision rationale: The request is for the use of a medication in the category of an anti-epileptic drug (AED). These medications are recommended for certain types of neuropathic pain. Most of the randomized clinical control trials involved include post-herpetic neuralgia and painful polyneuropathy such as in diabetes. There are few trials, which have studied central pain or radiculopathy. The MTUS guidelines state that a good response to treatment is 50% reduction in pain. At least a 30% reduction in pain is required for ongoing use, and if this is not seen, this should trigger a change in therapy. There also should be documentation of functional improvement and side effects incurred with use. Disease states which prompt use of these medications include post-herpetic neuralgia, spinal cord injury, chronic regional pain syndrome, lumbar spinal stenosis, post-operative pain, and central pain. There is inadequate evidence to support use in non-specific axial low back pain or myofascial pain. In this case, there is lack of documentation of adequate pain reduction for continued use. The records also do not reveal functional improvement or screening measures as required. As such, the request is not medically necessary.