MAXIMUS Federal Services

Case Number:	CM13-0035905		
Date Assigned:	12/13/2013	Date of Injury:	07/01/2011
Decision Date:	02/28/2014	UR Denial Date:	09/18/2013
Priority:	Standard	Application Received:	10/18/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in FFamily Practice and is licensed to practice in California. 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 physician 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/services. He/She is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 53 year old male who reported an injury on 07/01/2011 due to a slip and fall which reportedly caused injury to his left wrist. The patient was conservatively treated; however, ultimately underwent left wrist surgery with pin placement in 11/2011. The patient developed chronic pain post-surgically. Additional surgical intervention was recommended. However, the patient elected conservative treatments to include rest, ice, a wrist brace, and medication management. The patient's most recent clinical evaluation revealed decreased range of motion of the left wrist with a positive Tinel's sign and slightly decreased motor strength with decreased sensation. It was noted that the patient's pain medications do offer temporary relief, and improve the patient's ability to sleep. The patient's diagnoses included status post intra-articular distal radius fracture with residual pain. The patient's treatment plan included medication usage, a drug screen, a TENS unit, and electrodiagnostic studies of the bilateral upper extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Compounded Ketoprofen 20% in PLO gel, 120gms: Upheld

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

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

Decision rationale: The requested compounded ketoprofen 20% in PLO gel, 120 g is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not support the use of ketoprofen as a topical agent as it is not FDA approved for this formulation. The California Medical Treatment Utilization Schedule states that any medication that contains 1 drug or drug class that is not supported by guideline recommendations is not recommended. Therefore, the use of ketoprofen as a topical agent is not indicated. As such, the requested compounded ketoprofen 20% in PLO gel, 120 g is not medically necessary or appropriate.

Compounded Cyclophene 5% in PLO gel, 120gms: Upheld

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

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

Decision rationale: The requested compounded Cyclophene 5% in PLO gel; 120 g is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not support the use of Cyclophene as a topical agent as it is not FDA approved for this formulation. The California Medical Treatment Utilization Schedule states that any medication that contains 1 drug or drug class that is not supported by guideline recommendations is not recommended. Therefore, the use of Cyclophene as a topical agent is not indicated. As such, the requested compounded Cyclophene 5% in PLO gel; 120 g is not medically necessary or appropriate.

Synaprn (10mg/1ml) oral suspension 500ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Ongoing Management and Glucosamine (and Chondroitin Sulfate) Page(s): s 70, 50.

Decision rationale: The requested Synapryn (10 mg/1 mL) oral suspension 500 mL is not medically necessary or appropriate. This is a compounded medication with glucosamine and Tramadol. The California Medical Treatment Utilization Schedule recommends the use of glucosamine for patients who have osteoarthritic pain. The clinical documentation submitted for review does not provide any evidence that the patient's pain is related to osteoarthritis. The California Medical Treatment Utilization Schedule recommends the use of Tramadol be supported by a quantitative assessment of pain relief, documentation of functional benefit, managed side effects, and monitoring for aberrant behavior. The clinical documentation submitted for review does provide evidence that the patient is regularly monitored for aberrant

behavior. However, the clinical documentation does not provide any evidence of functional benefit or a quantitative assessment of pain relief related to this medication. Additionally, the clinical documentation does not provide any evidence that the patient cannot tolerate a regular oral formulation and that a liquid formulation is required. Therefore, the continued use of this medication would not be indicated. As such, the requested Synapryn (10 mg/1 mL) oral suspension 500 mL is not medically necessary or appropriate.

Tabradol (1mg/1ml) oral suspension 250ml: Upheld

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

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

Decision rationale: The requested Tabradol 1 mg/1ml (oral suspension 250 mL) is not medically necessary or appropriate. The requested medication contains Cyclobenzaprine. The California Medical Treatment Utilization Schedule recommends muscle relaxants for the management of pain and muscle spasms for short durations. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration. Additionally, the patient's most recent clinical exam findings did not include any evidence of muscle spasms that would benefit from a muscle relaxant. Also, the clinical documentation did not provide any evidence that the patient could not tolerate solid formulation of this medication. There was no port provided that the patient required an oral liquid formulation of this medication. Therefore, continued use would not be indicated. As such, the requested Tabradol (1mg/1 mL) oral suspension 250 mL is not medically necessary or appropriate.

Deprezine (15mg/1ml) oral suspension 250ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The requested Deprezine (15 mg/1 mL) oral suspension 250 mL is not medically necessary or appropriate. The requested medication contains Ranitidine. The California Medical Treatment Utilization Schedule recommends the use of gastrointestinal protectant when the patient is at risk for developing gastrointestinal disturbances related to medication usage. The clinical documentation does not provide an adequate assessment of the patient's gastro intestinal system to support that the patient is at risk for development of disturbances related to medication usage. Additionally, the clinical documentation does not support the need for an oral suspension of this medication. Therefore, continued use would not be indicated. As such, the requested Deprezine (15 mg/1 mL) oral suspension 250 mL is not medically necessary or appropriate.

Dicopanol (5mg/1ml) oral suspension 150ml: 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 Official Disability Guidelines (ODG) Pain Chapter, Insomnia Treatments

Decision rationale: The requested Dicopanol (5 mg/1 mL) oral suspension 150 mL is not medically necessary or appropriate. The requested medication contains diphenhydramine. Official Disability Guidelines state that sedating antihistamines have been suggested as sleep aids; however, tolerance seems to develop within a few days. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration of time. Therefore, continued use would not be supported. Additionally, the clinical documentation does not support the need for a liquid formulation for this patient. Also, there is no adequate assessment of the patient's sleep hygiene to support the need for medication management of insomnia related to pain. As such, the requested Dicopanol (5 mg/1 mL) oral suspension 150 mL is not medically necessary or appropriate.

Fanatrex (Gabapentin) (25mg/1ml) oral suspension 420ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and Antiepilepsy drugs (AEDs) Page(s): s 60, 16.

Decision rationale: Decision for Fanatrex (gabapentin) (25 mg/1 mL) oral suspension 420 mL is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration of time. California Medical Treatment Utilization Schedule recommends the continued use of medications in the management of chronic pain be supported by a quantitative assessment of symptom relief, and documentation of increased functional benefit. It is noted that the patient has temporary pain relief with medications and an improved ability to have restful sleep; however, there is no objective evidence of functional improvement or symptom relief. Additionally, the clinical documentation does not provide any evidence that the patient requires an oral suspension of this medication. Therefore, the continued use would not be indicated. As such, Fanatrex (gabapentin) (25 mg/1 mL) oral suspension 420 mL is not medically necessary or appropriate.

MRI right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): s 268-269.

Decision rationale: MRI of the right wrist is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine states, "Imaging studies to clarify the diagnosis may be warranted if the medical history and physical examination suggests specific disorders." The clinical documentation submitted for review does to provide any evidence of deficits of the right wrist that would require an imaging study. Therefore, the MRI of the right wrist is not medically necessary or appropriate.

EMG left upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): s 268-269.

Decision rationale: The requested EMG of the left upper extremity is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient underwent an electrodiagnostic studies in 03/2013 that did not reveal any significant electrodiagnostic abnormalities. The American College of Occupational and Environmental Medicine recommends the use of electrodiagnostic studies when clarification is needed between neurological deficits revealed to peripheral nerve impingement. However, the clinical documentation submitted for review does not provide any evidence of a significant change in the patient's presentation to support the need for an additional electrodiagnostic study. Therefore, the requested EMG of the left wrist is not medically necessary or appropriate.

EMG right upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): s 268-269.

Decision rationale: The requested EMG of the right upper extremity is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends electrodiagnostic studies and the clarification of nerve root impingement. The clinical documentation submitted for review does not provide any evidence that the patient has any right sided upper extremity deficits that would require clarification by an electrodiagnostic study. Therefore, the EMG of the right upper extremity is not medically necessary or appropriate.

NCV left upper extremity: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): s 268-269.

Decision rationale: The requested NCV of the left upper extremity is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient underwent an electrodiagnostic studies in 03/2013 that did not reveal any significant electrodiagnostic abnormalities. The American College of Occupational and Environmental Medicine recommends the use of electrodiagnostic studies when clarification is needed between neurological deficits revealed to peripheral nerve impingement. However, the clinical documentation submitted for review does not provide any evidence of a significant change in the patient's presentation to support the need for an additional electrodiagnostic study. Therefore, the requested NCV of the left wrist is not medically necessary or appropriate.

NCV right upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): s 268-269.

Decision rationale: The requested NCV of the right upper extremity is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends electrodiagnostic studies and the clarification of nerve root impingement. The clinical documentation submitted for review does not provide any evidence that the patient has any right sided upper extremity deficits that would require clarification by an electrodiagnostic study. Therefore, the NCV of the right upper extremity is not medically necessary or appropriate.

TENs unit (rental/purchase unspecified): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit Page(s): 114.

Decision rationale: The requested TENS unit is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has previously undergone surgical intervention for the patient's injury and has developed moderate to severe chronic pain. The California Medical Treatment Utilization Schedule recommends the use of a TENS unit be based on a 30 day clinical trial to support continued use. The clinical documentation submitted for review does not provide any evidence that the patient has undergone a clinical trial to support the purchase of a TENS unit. Therefore, the requested TENS unit (rental/purchase unspecified) is not medically necessary or appropriate.

Hot/Cold unit (rental/purchase unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): s 271-273. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Continuous Flow Cryotherapy

Decision rationale: The requested hot/cold unit (for rental/purchase unspecified) is not medically necessary or appropriate. Official Disability Guidelines do not support the use of a cold therapy unit in the absence of surgical intervention. The clinical documentation submitted for review does not provide any evidence that the patient has failed to respond to self managed hot pack and cold pack applications that are recommended by the American College of Occupational and Environmental Medicine. Therefore, the need for a hot/cold unit (rental/purchase unspecified) is not medically necessary or appropriate.

FCE (Functional Capacity Evaluation): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty, Functional Capacity Evaluations (FCE)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): s 77-89.

Decision rationale: The requested Functional Capacity Evaluation is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends the use of Functional Capacity Evaluations to obtain a more precise delineation of a patient's capabilities that is available from routine physical examination. Official Disability Guidelines recommend the use of a Functional Capacity Evaluation when the patient is at or near maximum medical improvement. The clinical documentation submitted for review does not provide any evidence that the patient is at or near maximum medical improvement. Therefore, the need for a Functional Capacity Evaluation is not clearly established. As such, the requested Functional Capacity Evaluation is not medically necessary or appropriate.