

Case Number:	CM14-0002469		
Date Assigned:	01/24/2014	Date of Injury:	03/31/2006
Decision Date:	07/08/2014	UR Denial Date:	12/23/2013
Priority:	Standard	Application Received:	01/07/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery 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 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/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 injured worker is a 46 year old female injured on 03/31/06 due to a slip and fall. The patient underwent laminectomy in 2006 with continued back pain status post surgical intervention. Chief complaint post-operatively was constant low back pain radiating to bilateral lower extremities. Clinical note dated 02/19/14 indicated the patient presented for physical therapy evaluation. Physical examination of the lumbar spine revealed decreased range of motion, straight leg raise positive bilaterally, strength of bilateral lower extremities equal bilaterally and within normal limits, deep tendon reflexes at the patella were bilaterally symmetric and within the limits of normal with deep tendon reflexes at the Achilles decreased bilaterally, there were no areas of decreased sensation to light touch in the lower extremities. Previous abnormal electromyography of the lumbar spine and lower extremities in a pattern consistent with L4-5 and L5-S1 radiculopathy was noted. The patient complained of constant moderate to severe low back pain radiating to bilateral lower extremities with associated numbness and tingling, left greater than right. The patient reported weather changes increased her pain. The patient rated her pain at 8-9/10. The patient also stated increased feelings of anxious and depressed state due to inability to work and perform normal activities of daily living. The patient was prescribed Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclophene, and Ketoprofen cream. Retrospective review for Synapryn 10mg/mL oral suspension 500mL between 11/19/13 and 12/19/13, Tabradol 1mg/mL oral suspension 250mL, Deprizine 15mg/mL oral suspension 250mL, Dicopanol 5mg/mL oral suspension 150mL, Fanatrex 25mg/mL oral suspension 420mL, Ketoprofen topical cream, and Cyclophene topical cream was initially non-certified on 12/23/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE SYNAPRYN 10MG/1ML ORAL SUSPENSION 500ML BETWEEN 11/19/2013 AND 12/19/2013: 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 (Chronic), Compound Medications.

Decision rationale: Current guidelines indicate the use of suspension medications when there is documentation of inability to swallow or tolerate pill form of the prescribed medication. The documentation failed to provide that documentation. Without further documentation to justify oral suspension of the medication, the request for Retrospective Synapryn 10mg/1ml Oral Suspension 500ml Between 11/19/2013 And 12/19/2013 cannot be recommended as medically necessary.

RETROSPECTIVE TABRADOL IMG/ML ORAL SUSPENSION 250ML BETWEEN 11/19/2013 AND 12/19/2013: 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 (Chronic), Compound Medications.

Decision rationale: Current guidelines indicate the use of suspension medications when there is documentation of inability to swallow or tolerate pill form of the prescribed medication. The documentation failed to provide that documentation. Without further documentation to justify oral suspension of the medication, the request for Retrospective Tabradol Img/MI Oral Suspension 250ml Between 11/19/2013 And 12/19/2013 cannot be recommended as medically necessary.

RETROSPECTIVE DEPRIZINE 15MG/ML ORAL SUSPENSION 250ML BETWEEN 11/19/2013 AND 12/19/2013: 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 (Chronic), Compound Medications.

Decision rationale: Current guidelines indicate the use of suspension medications when there is documentation of inability to swallow or tolerate pill form of the prescribed medication. The documentation failed to provide that documentation. Without further documentation to justify oral suspension of the medication, the request for Retrospective Deprizine 15mg/MI Oral Suspension 250ml Between 11/19/2013 And 12/19/2013 cannot be recommended as medically necessary.

RETROSPECTIVE DICOPANOL 5MG/ML ORAL SUSPENSION 150ML BETWEEN 11/19/2013 AND 12/19/2013: 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 (Chronic), Compound Medications.

Decision rationale: Current guidelines indicate the use of suspension medications when there is documentation of inability to swallow or tolerate pill form of the prescribed medication. The documentation failed to provide that documentation. Without further documentation to justify oral suspension of the medication, the request for Retrospective Dicopanol 5mg/MI Oral Suspension 150ml Between 11/19/2013 And 12/19/2013 cannot be recommended as medically necessary.

RETROSPECTIVE FANATREX 25MG/ML ORAL SUSPENSION 420ML BETWEEN 11/19/2013 AND 12/19/2013: 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 (Chronic), Compound Medications.

Decision rationale: Current guidelines indicate the use of suspension medications when there is documentation of inability to swallow or tolerate pill form of the prescribed medication. The documentation failed to provide that documentation. Without further documentation to justify oral suspension of the medication, the request for Retrospective Fanatrex 25mg/MI Oral Suspension 420ml Between 11/19/2013 And 12/19/2013 cannot be recommended as medically necessary.

RETROSPECTIVE KETOPROFEN TOPICAL CREAM BETWEEN 11/19/2013 AND 12/19/2013: Upheld

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

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

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, CAMTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. This compound contains: which have not been approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore Retrospective Ketoprofen Topical Cream Between 11/19/2013 And 12/19/2013 cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

RETROSPECTIVE CYCLOPHENE TOPICAL CREAM BETWEEN 11/19/2013 AND 12/19/2013: Upheld

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

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

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, CAMTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore Retrospective Cyclophene Topical Cream Between 11/19/2013 And 12/19/2013 cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.