

Case Number:	CM14-0137082		
Date Assigned:	09/05/2014	Date of Injury:	07/27/2011
Decision Date:	10/14/2014	UR Denial Date:	08/22/2014
Priority:	Standard	Application Received:	08/25/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 38 year old male injured on 07/27/11 as a result of cumulative trauma resulting in low back pain with radiculopathic symptoms into the right lower extremity. The diagnoses include lumbosacral herniated disc, lumbar spine pain, and lumbar spine radiculopathy. The clinical note dated 02/05/14 indicated the injured worker presented complaining of low back pain with right leg radiation into the foot. The injured worker reported pain significantly worse following a fall at work that is constant with no improvement. Physical examination revealed diminished sensation in pain distribution predominantly in the S1 dermatome, straight leg raise grossly positive over sciatic notch on the right, reflexes in the lower extremity knee 2+ and ankle jerks 0 bilaterally, gait and coordination within normal limits. The treatment plan included updated MRI of the lumbar spine. It was also noted the injured worker weighed approximately 380 lbs. and was referred for a weight loss program. There was no additional documentation regarding medication management or a complete list of medications provided. The initial request was non-certified on 08/22/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective for 1/27/2014 Fanatrex 25mg/420mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Gabapentin (Neurontin) Page(s): 49.

Decision rationale: As noted in the Chronic Pain Medical Treatment Guidelines, Fanatrex is the oral suspension form of gabapentin. There is no indication the injured worker has an inability to swallow requiring an oral suspension formulation versus regular pill form of this medication. As such, the request for Retrospective for 1/27/2014 Fanatrex 25mg/420mg cannot be recommended as medically necessary.

Retrospective for 1/27/2014 Synapryn 10mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram, Ultram ER, generic available in immediate releas.

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

Decision rationale: There is no indication the injured worker has an inability to swallow requiring an oral suspension formulation versus regular pill form of this medication. As such, the request for Retrospective for 1/27/2014 Synapryn 10mg cannot be recommended as medically necessary.

Retrospective for 1/27/2014 Tabradol 1mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flexeril (cyclobenzaprine).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Cyclobenzaprine Page(s): 41.

Decision rationale: There is no indication the injured worker has an inability to swallow requiring an oral suspension formulation versus regular pill form of this medication. As such, the request for Retrospective for 1/27/2014 Tabradol 1mg cannot be recommended as medically necessary.

Retrospective for 1/27/2014 topical compound Ketoprofen 20% 165gms: Upheld

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

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. 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 for 1/27/2014 topical compound Ketoprofen 20% 165gms cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

Retrospective for 1/27/2014 topical compound Cyclobenzaprine 5% cream 100gms: Upheld

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

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. 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 for 1/27/2014 topical compound Cyclobenzaprine 5% cream 100gms cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

Retrospective for 1/27/2014 Dicoprofanol 5mg/1ml: 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), Pain (chronic)

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), Insomnia treatment

Decision rationale: There is no indication the injured worker has an inability to swallow requiring an oral suspension formulation versus regular pill form of this medication. As such, the request for Retrospective for 1/27/2014 Dicoprofanol 5mg/1ml cannot be recommended as medically necessary.

Retrospective for 1/27/2014 Deprizine 5mg/250ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: There is no indication the injured worker has an inability to swallow requiring an oral suspension formulation versus regular pill form of this medication. As such, the request for Retrospective for 1/27/2014 Deprizine 5mg/250ml cannot be recommended as medically necessary.