MAXIMUS Federal Services

Case Number:	CM14-0030169		
Date Assigned:	06/20/2014	Date of Injury:	03/31/2006
Decision Date:	07/29/2014	UR Denial Date:	02/24/2014
Priority:	Standard	Application Received:	03/10/2014

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 Physical Medicine and Rehabilitation, and is licensed to practice in Texas and Oklahoma. 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 36-year-old female who reported an injury on 03/15/2006 due to cumulative trauma while performing normal job duties. The injured worker's treatment history included chiropractic care, physical therapy, surgical intervention and multiple medications. The injured worker was evaluated on 01/21/2014. It was documented that the patient had burning and radicular neck pain, and moderate to severe low back pain radiating into the bilateral lower extremities, rated at 7/10 to 8/10. It was documented that medications provided a temporary relief and allowed for restful sleep. Physical findings included tenderness to the cervical paraspinal musculature, trapezius and scalene muscles with decreaed range of motion and decreased bilateral sensation and weakness. Evaluation of the lumbosacral spine included tenderness to palpation of the bilateral paraspinous musculature with decreased range of motion and decreased sensation and weakness. The injured worker's diagnoses included cervicalgia, status post lumbar spine laminectomy with residual pain, lumbar radiculopathy, and posttraumatic stress syndrome. On 01/21/2014, a request for a refill of medications was provided. Medications included synaprin, tabradol, deprizine, dicopanal, and fanatrex.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective request for 1 prescription Synapryn: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Opioids, Ongoing Management, Medication for Chronic Pain and Glucosamine (and Chondroitin Sulfate) Page(s): 78, 16, 60, 50.

Decision rationale: The requested Synapryn is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient has been on this medication since at least 08/2012. The requested medication is a compounded medication that contains glucosamine and tramadol. The California Medical Treatment Utilization Schedule recommends continued use of opioids be supported by documentation of functional benefit, evidence of pain relief, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the injured worker is monitored for aberrant behavior and has improved sleep patterns secondary to pain relief provided by medications. However, a quantitative assessment of pain relief to support the efficacy and continued use of this medication is not provided. Also, there is no documentation to support the need for a liquid formulation. The California Medical Treatment Utilization Schedule recommends glucosamine to assist in the management of osteoarthritis pain. However, the California Medical Treatment Utilization Schedule recommends medications used in the management of chronic pain be supported by documentation of functional benefit and pain relief. The clinical documentation fails to identify a quantitative assessment of pain relief to support the continued use of this medication. Additionally, there is no documentation to support the need for an oral formulation of this medication. Furthermore, the request as it is submitted does not specifically identify a dosage, frequency, or quantity. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Synapryn is not medically necessary or appropriate.

Prospective request for 1 prescription Tabradol: 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 Muscle Relaxants Page(s): 63.

Decision rationale: The requested Tabradol is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient has been on this medication since at least 08/2012. The requested medication is a liquid formulation containing cyclobenzaprine. The California Medical Treatment Utilization Schedule does not recommend the use of muscle relaxants in the management of chronic pain. The use of muscle relaxants should be limited to a short duration of treatment for acute exacerbation's of chronic pain. The clinical documentation does indicate that the patient has been on this medication for an extended duration. Therefore, continued use would not be supported. Furthermore, the request as it is submitted does not specifically identify a dosage or frequency, or quantity. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Tabradol is not medically necessary or appropriate.

Prospective request for 1 prescription Deprizine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk.

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

Decision rationale: The requested deprizine is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient has been on this medication since at least 08/2012. The requested medication is a compounded liquid form of ranitidine. The California Medical Treatment Utilization Schedule recommends the use of gastrointestinal protectants for patients who are at risk for developing gastrointestinal events related to medication usage. The clinical documentation does not provide an adequate assessment of the patient's gastrointestinal system to support that they are at risk for developing gastrointestinal symptoms related to medication usage. Therefore, continued use of this medication would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment, dosage, or quantity. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested deprizine is not medically necessary or appropriate.

Prospective request for 1 prescription Dicopanol: 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) Chapter, 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) Pain Chapter, Insomnia Treatments.

Decision rationale: The requested dicopanol is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient has been on this medication since at least 08/2012. The requested medication is a liquid formulation of diphenidine. The California Medical Treatment Utilization Schedule does not address insomnia-related treatments. The Official Disability Guidelines recommend the use of this medication for short durations of treatment. The clinical documentation does indicate that the patient has been on this medication for an extended duration. Therefore, continued use would not be supported. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. Furthermore, the request as it is submitted does not clearly identify a dosage or frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested dicopanol is not medically necessary or appropriate.

Prospective request for 1 prescription Fanatrex: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and Anti-Epilyptics Page(s): 60, 16.

Decision rationale: The requested Fanatrex is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient has been on this medication since at least 08/2012. The California Medical Treatment Utilization Schedule recommends anticonvulsants as a first-line medication in the management of chronic pain. However, the California Medical Treatment Utilization Schedule recommends the continued use of any medication used in the management of chronic pain be supported by the documented functional benefit and a quantitative assessment of pain relief. The clinical documentation submitted for review does indicate that the patient has improved sleep patterns due to medication usage. However, there is not a quantitative assessment of pain reduction related to medication usage. Therefore, the efficacy of this medication cannot be determined. Additionally, the clinical documentation fails to provide any support for the need of a liquid formulation of this medication. Furthermore, the request as it is submitted does not clearly identify a dosage, frequency, or quantity. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the prospective request for 1 prescription of Fanatrex is not medically necessary or appropriate.

Prospective request for 1 pain management consultation: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: The request for 1 pain management consultation is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine does recommend specialty consultations for patients at risk for delayed recovery when the injured worker's treating provider has exhausted all diagnostic and conservative treatments within their scope of practice. The clinical documentation submitted for review does not justify that the treating provider has exhausted all resources within his scope of practice and would require additional expertise in treatment planning. Therefore, the need for a pain management consultation is not supported. As such, the requested 1 pain management consultation is not medically necessary or appropriate.