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| Case Number: | CM14-0096166 | | |
| Date Assigned: | 09/15/2014 | Date of Injury: | 04/03/2003 |
| Decision Date: | 11/17/2014 | UR Denial Date: | 06/11/2014 |
| Priority: | Standard | Application Received: | 06/24/2014 |

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 Family Medicine 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 records presented for review indicate that this 67 year-old male was reportedly injured on April 3, 2003. The mechanism of injury is noted as a cumulative trauma type event. The most recent progress note dated April 1, 2014, indicated that there are ongoing complaints of low back pain. The physical examination demonstrated a decrease in lumbar spine range of motion, and ability to heel and toe walk; however, requires a cane for ambulation. Straight leg raising was reported to be negative. The left examination was not contributory. Diagnostic imaging studies objectified no significant acute interosseous abnormalities. Previous treatment includes multiple medications and pain management interventions. A request had been made for multiple medications and was not certified in the pre-authorization process on June 24, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Deprizine (DOS: 10/14/2013, 02/17/2014, 03/21/2014): Upheld

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

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

Decision rationale: This request is a kit that contains Ranitidine Hydrochloride oral suspension as well as other inactive and unstated products. The submitted records do not include an updated clinical note to indicate medical necessity for this product and guidelines do not support this product as it has unstated ingredients. This is a compounded product. As such, this request is not supported by guidelines and/or records; therefore, is not medically necessary.

Retrospective Dicopanол (DOS: 10/14/2013, 02/17/2014, 03/21/2014): Upheld

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

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

Decision rationale: This request is a kit that contains diphenhydramine as well as other inactive and unstated products. The submitted records do not include an updated clinical note to indicate medical necessity for this product and guidelines do not support this product as it has unstated ingredients. This is a compounded product. As such, this request is not supported by guidelines and/or records; therefore, is not medically necessary.

Retrospective Fantrex (DOS: 10/14/2013, 02/17/2014, 03/21/2014): Upheld

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

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

Decision rationale: This request is for Fantrex. This medication is a compounded topical medication with unspecified ingredients. This is also included in this product is Gabapentin, which is to be used for neuropathic pain. There is a lack of updated clinical notes to indicate continued neuropathic pain for the injured worker to warrant this type of medication and there is lack of support from guidelines. Therefore, this request is not medically necessary.

Retrospective Synapryn (DOS: 10/14/2013, 02/17/2014, 03/21/2014): Upheld

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

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

Decision rationale: This request is for Synapryn which includes unspecified ingredients. It also includes Tramadol, which is not a first line medication. Also, adherence to the 4 A's should be documented, including drug screens and effective analgesia. There is lack of clinical records to

indicate the medical necessity for this medication and there is lack of support from guidelines for the requested drug. Therefore, this request is not medically necessary.

Retrospective Tabradol (DOS: 10/14/2013, 02/17/2014, 03/21/2014): Upheld

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

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

Decision rationale: This request is a compounded product with cyclobenzaprine. Guidelines do not support compounded products as there is lack of long term scientific studies demonstrating overall efficacy and safety. There is also lack of an updated clinical note to warrant the medical necessity for this product. Therefore, this request is not medically necessary.

Retrospective Cyclophene (Dos: 10/14/2013, 02/17/2014, 03/21/2014):: Upheld

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

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

Decision rationale: This product is an apparent compounded product. There is lack of an updated clinical note to indicate the medical necessity of this product. There is no indication for muscle spasms, pain, or information to warrant this product. There is lack of scientific studies demonstrating the overall efficacy of this product. Therefore, this request is not medically necessary.

Retrospective Ketoprofen Cream (DOS: 10/14/2013, 02/17/2014, 03/21/2014): Upheld

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

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

Decision rationale: The request is for Ketoprofen cream which is a topical cream. Guidelines indicate that there is lack of scientific information regarding this product for long term safety and efficacy. There was also a lack of an updated physical examination to indicate that there is a need for this product. Therefore, this request is not medically necessary.

Retrospective Physical Therapy (3-times per week for 6-weeks, DOS: 10/14/2013, 02/17/2014, 03/21/2014): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

Decision rationale: This request is for physical therapy. There is no indication for the number of physical therapy sessions requested or for the modalities. Guidelines support active versus passive therapy. There is no indication of the exact number of physical therapy sessions already attended by this individual. Therefore, this request is not medically necessary.

Retrospective Chiropractic Treatment (3-times per week for 6-weeks, DOS: 10/14/2013, 02/17/2014, 03/21/2014): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58.

Decision rationale: This request is for chiropractic treatment 3 x 6. Guidelines do not support maintenance therapy for low back issues in the form of chiropractic treatment. If there is documentation of a significant flare, 1-2 visits would be supported. The records do not support a recent flare of this injured worker's pain to support 1-2 treatments of chiropractic treatment. Therefore, this request is not medically necessary.

Retrospective Return Appointments in 4-weeks (DOS: 10/14/2013, 02/17/2014, 03/21/2014): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Back Chapter, Office visits

Decision rationale: The last clinical note provided for this review was 04/01/14. At that time, there was no indication of a need for a follow up as there has been approximately six months from the last clinical visit. Therefore, the request is not medically necessary.