

Case Number:	CM14-0169222		
Date Assigned:	10/17/2014	Date of Injury:	05/01/2013
Decision Date:	04/23/2015	UR Denial Date:	09/25/2014
Priority:	Standard	Application Received:	10/14/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management

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 52 year old male who sustained an industrial injury on 5/1/13. The injured worker reported symptoms in the right shoulder, right upper extremity, back and right groin. The injured worker was diagnosed as having right shoulder impingement syndrome, shoulder pain, elbow pain, right wrist carpal tunnel syndrome, radiculitis lower extremity, lumbar disc displacement herniated nucleus pulposus and abdominal pain rule out inguinal hernia. Treatments to date have included oral pain medications. Currently, the injured worker complains of pain in the right shoulder, right upper extremity, back and right groin. The low back pain was noted to radiate to the lower extremities. There were associated numbness, tingling and weakness of the extremities. There were objective findings of decreased sensation over the L5, S1 dermatomes and the hands. The plan of care was for medication prescriptions and a follow up appointment at a later date. The medications listed in the records are Tramadol, Deprizine, Dicopropranol, Tabradol, Flurbiprofen and Fanatrex. A Utilization Review determination was rendered recommending non certification for Fanaprex 25mg/ml 420ml DOS 8/19/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fanatrex 25 mg/ml, 420 ml, provided on August 19, 2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epileptic Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 16-22. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Anticonvulsants.

Decision rationale: The CA MTUS and the ODG guidelines recommend that anticonvulsant medications can be utilized for the treatment of neuropathic and radicular pain. The records indicate that the patient had subjective, objective and radiological findings consistent with lumbar radiculopathy. There are findings of neuropathy of the hands and lower extremities. There is no documentation of failure of treatment with gabapentin that is not compounded with other products. The guidelines recommend utilization of non compounded products to better titrate medication dosage regimen and evaluate efficacy. The criteria for the use of Fanaprex 25mg/ml, 420ml DOS 9/19/2014 was not met. Therefore, the request is not medically necessary.