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| Case Number: | CM15-0135078 | | |
| Date Assigned: | 07/23/2015 | Date of Injury: | 02/08/2013 |
| Decision Date: | 09/25/2015 | UR Denial Date: | 06/17/2015 |
| Priority: | Standard | Application Received: | 07/13/2015 |

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 31-year-old male who sustained an industrial injury on February 8, 2013. He has reported neck pain, bilateral elbow pain, wrist pain, mid back pain, low back pain, and bilateral knee pain and has been diagnosed with cervicalgia, cervical spine sprain, strain, medial epicondylitis, bilateral elbows, bilateral elbow joint effusion, right wrist sprain strain, left wrist De Quervain's tenosynovitis, left wrist carpal tunnel syndrome, thoracic spine pain, thoracic sprain strain, low back pain, lumbar spine sprain strain, lumbar disc displacement herniated nucleus pulposus, bilateral knee sprain strain, bilateral knee joint effusion, and rule out bilateral knee internal derangement. Treatment has included medical imaging, medications, physical therapy, manipulation, acupuncture, and injections. There was plus 2 tenderness to the cervical spine. Range of motion was decreased. There was plus 2 tenderness to palpation at the medial epicondyles. There was decreased range of motion to bilateral elbows. There was plus 2 tenderness to palpation of the bilateral wrists and decreased range of motion. There was tenderness to the lumbar spine with decreased range of motion. There was plus 1 tenderness to palpation over the medial and lateral joint line and to the patellofemoral joint bilaterally. There was decreased range of motion to both the left and right knee. The treatment request included medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Synapryn 10mg/1ml susp 500ml 1 tsp TID: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 111, 113, 119. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Opioids.

Decision rationale: The CA MTUS and the ODG guidelines recommend that opioids can be utilized for short term treatment of exacerbation of musculoskeletal pain when standard treatment with NSAIDs and PT have failed. The Synapryn products contain tramadol and glucosamine in compounded formulation. The utilization of compounded medications is reserved as a second line option when non compounded medications have failed. The records did not show any indication for the use of compounded liquid formulations of medications. There is no documentation of nutritional deficiency that required the inclusion of nutritional supplements in the medication formulations. The guidelines recommend that medications be utilized individually to evaluate efficacy. The criteria for the use of Synapryn 10mg/ml susp 500ml 1tsp TID was not met. The request is not medically necessary

Fanatrex 25mg/ml 420ml 1 tsp as directed: Upheld

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

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 Opioids.

Decision rationale: The CA MTUS and the ODG guidelines recommend that anticonvulsant can be utilized for the treatment of neuropathic pain and chronic pain syndrome. The utilization of compounded medications is reserved as a second line option when non compounded medications have failed. The Fanatrex product contains gabapentin with non active ingredients. The records did not show any indication for the use of compounded liquid formulations of medications.

There is no documentation of nutritional deficiency that required the inclusion of nutritional supplements in the medication formulations. The guidelines recommend that medications be utilized individually to evaluate efficacy. The criteria for the use of Fanatrex 25mg/ml 420ml 1tsp TID was not met. The request is not medically necessary.

Tabradol 1mg/1ml sups 250ml 1tsp 2-3 x a day: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 41. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Muscle Relaxants.

Decision rationale: The CA MTUS and the ODG guidelines recommend that muscle relaxants can be utilized for short-term treatment of exacerbation of musculoskeletal pain. The utilization of compounded medications is reserved as a second line option when non compounded medications have failed. The records did not show any indication for the use of compounded liquid formulations of medications. There is no documentation of nutritional deficiency that required the inclusion of nutritional supplements in the medication formulations. The guidelines recommend that medications be utilized individually to evaluate efficacy. The criteria for the use of Synapryn (cyclobenzaprine) 1mg/ml 250ml 1 Tbs 2-3 X/day was not met. The request is not medically necessary.

Ketoprofen 20% 167gm: 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 9792.24.2 Page(s): 67-73. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter NSAIDs.

Decision rationale: The CA MTUS and the ODG guidelines recommend that topical analgesics products can be utilized for the treatment of localized neuropathic pain when treatment with oral formulations of first line anticonvulsant and antidepressant medications have failed. The records did not show subjective or objective findings consistent with a diagnosis of localized pain such as CRPS. There is no documentation of failure or contraindication to orally administered NSAIDs. The utilization of topical ketoprofen can be associated with the development of photo sensitive dermatitis. The criteria for the use of ketoprofen 20% 167 gm was not met. The request is not medically necessary.

Cyclobenzaprine 5% 110gm: 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 9792.24.2 Page(s): 41. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Muscle Relaxants.

Decision rationale: The CA MTUS and the ODG guidelines recommend that topical analgesics products can be utilized for the treatment of localized neuropathic pain when treatment with oral formulations of first line anticonvulsant and antidepressant medications have failed. The records did not show subjective or objective findings consistent with a diagnosis of localized pain such as CRPS. There is no documentation of failure of treatment with orally administered muscle relaxants. The patient is utilizing orally administered cyclobenzaprine concurrently. The guidelines did support the use of topical formulation of muscle relaxants. The criteria for the use of cyclobenzaprine 5% 110 gm was not met. The request is not medically necessary.

Deprizine 250ml 2tsp qd: 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 9792.24.2 Page(s): 67-73. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter NSAIDs.

Decision rationale: The CA MSTU and the ODG guidelines recommend that H2 antagonists can be utilized for the treatment of gastrointestinal disease. The utilization of compounded medications is reserved as a second line option when non compounded medications have failed. The Deprizine product contains ranitidine and inactive ingredients. The records did not show any indication for the use of compounded liquid formulations of medications. There is no documentation of nutritional deficiency that required the inclusion of nutritional supplements in the medication formulations. The guidelines recommend that medications be utilized individually to evaluate efficacy. The criteria for the use of Deprizine 15mg/ml 250ml 2tsp QD was not met. The request is not medically necessary.

Dicopanol 6mg. ml qhs: 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 9792. 21. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

Decision rationale: The CA MTUS and the ODG guidelines recommend that H1 antagonist can be utilized for the treatment of allergic reactions. The records did not show subjective or objective findings consistent with chronic allergy. The utilization of compounded medications is reserved as a second line option when non compounded medications have failed. The records did not show any indication for the use of compounded liquid formulations of medications. There is no documentation of nutritional deficiency that required the inclusion of nutritional supplements in the medication formulations. The guidelines recommend that medications be utilized individually to evaluate efficacy. The criteria for the use of Dicopanol containing diphenhydramine 5mg/ml susp 150ml 6mg/ml qhs was not met. The request is not medically necessary.