

Case Number:	CM14-0134920		
Date Assigned:	09/05/2014	Date of Injury:	08/29/2013
Decision Date:	10/08/2014	UR Denial Date:	07/21/2014
Priority:	Standard	Application Received:	08/21/2014

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 Florida. 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 59-year-old male who reported an injury on 08/29/2013. The mechanism of injury was not submitted for clinical review. Diagnoses included cervicalgia, sprain of ligaments in the cervical spine, lumbago, lumbar spine multilevel disc displacement, lumbar spine degenerative disc disease, lumbar spine radiculopathy, and anxiety disorder. Previous treatments included medication. Within the clinical note dated 06/05/2014 it was reported the injured worker complained of neck pain described as burning, radicular neck pain and muscle spasms. He rated his pain 6/10 to 7/10 in severity. The injured worker complained of low back pain rated 6/10 to 7/10 in severity. Upon the physical examination, the provider noted the injured worker had tenderness to palpation of the suboccipital region as well as over both scalene and trapezius muscles. The cervical spine range of motion was flexion at 35 degrees and extension at 35 degrees. The provider noted the injured worker had diminished sensation to pinprick and light touch over the C5, C6, C7, C8, and T1 dermatomes. The provider noted the injured worker had tenderness to palpation of the lumbar paraspinal muscles and lumbar sacral junction. The provider requested compounded ketoprofen PLO gel, compounded Cyclophene PLO gel, Synapryn, Tabradol, Deprizine, Dicopanol, and Fanatrex. However, a rationale was not submitted for clinical review. The Request for Authorization is not submitted for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Compounded Ketoprofen 20% in PLO gel, 120 grams: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112..

Decision rationale: The request for Compounded Ketoprofen 20% in PLO gel, 120 grams is not medically necessary. The California MTUS Guidelines recommend topical non-steroidal anti-inflammatory drugs (NSAIDs) for osteoarthritis and tendinitis, in particular that of the knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. The request submitted failed to provide the treatment site. Therefore, the request for Compounded Ketoprofen 20% in PLO gel, 120 grams is not medically necessary.

Compounded Cyclophene 5% in PLO gel, 120 grams: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112..

Decision rationale: The request for Compounded Cyclophene 5% in PLO gel, 120 grams is not medically necessary. The California MTUS Guidelines recommend topical NSAIDs for osteoarthritis and tendinitis, in particular that of the knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. The request submitted failed to provide the treatment site. Therefore, the request for Compounded Cyclophene 5% in PLO gel, 120 grams is not medically necessary.

Synapryn 10 mg/1 ml, 500 ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management, Page(s): 78..

Decision rationale: The request for Synapryn 10 mg/1 ml, 500 ml is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The Guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain

control. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. The provider failed to document an adequate and complete pain assessment within the documentation. Additionally, the use of a urine drug screen was not submitted for clinical review. Therefore, the request for Synapryn 10 mg/1 ml, 500 ml is not medically necessary.

Tabradol 1 mg/ml, 250 ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Page(s): 63, 64..

Decision rationale: The request for Tabradol 1 mg/ml, 250 ml is not medically necessary. The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbation in patients with chronic low back pain. The Guidelines do not recommend the use of the medication for longer than 2 to 3 weeks. The injured worker has been utilizing the medication since at least 04/2014. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request for Tabradol 1 mg/ml, 250 ml is not medically necessary.

Deprazine 15 mg/ml, 250 ml: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation website Drugs.com (www.drugs.com/pro/diphenhydramine.html)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13..

Decision rationale: The request for Deprazine 15 mg/ml, 250 ml is not medically necessary. The California MTUS Guidelines recommend antidepressants as a first line option for neuropathic pain. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, there is a lack of documentation indicating the injured worker is treated for neuropathic pain. Therefore, the request for Deprazine 15 mg/ml, 250 ml is not medically necessary.

Dicopanol 5 mg/ml, 150 ml: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Insomnia Treatment.

Decision rationale: The request for Dicopanol 5 mg/ml, 150 ml is not medically necessary. The Official Disability Guidelines note Dicopanol is used for insomnia treatment. Dicopanol is a sedating antihistamine to have been suggested for sleep aids. Tolerance seems to develop within a few days. Next day sedation has been noted as well as impaired psychomotor and cognitive function. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, there is a lack of documentation indicating the injured worker was treated for or diagnosed with insomnia. There is lack of objective and subjective findings indicating the injured worker had sleeping problems. Therefore, the request for Dicopanol 5 mg/ml, 150 ml is not medically necessary.

Fanatrex 25 mg/nl, 420 ml: Upheld

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

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

Decision rationale: The request for Fanatrex 25 mg/nl, 420 ml is not medically necessary. The California MTUS Guidelines note gabapentin has been shown to be effective for the treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first line treatment for neuropathic pain. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, there is a lack of documentation indicating the injured worker was treated for diabetic painful neuropathy or postherpetic neuralgia. Therefore, the request for Fanatrex 25 mg/nl, 420 ml is not medically necessary.