

Case Number:	CM15-0009514		
Date Assigned:	01/27/2015	Date of Injury:	02/15/2004
Decision Date:	03/26/2015	UR Denial Date:	12/24/2014
Priority:	Standard	Application Received:	01/16/2015

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: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 64-year-old female who reported an injury on 02/15/2004 due to an unknown mechanism of injury. The injured worker reportedly sustained an injury to her wrist and hands. The injured worker was evaluated on 12/03/2014. It was documented that the injured worker had slightly decreased pain and stiffness of the bilateral hands and wrists. Physical findings included decreased tenderness of the bilateral wrists and hands. It was noted that the injured worker had undergone x-rays that showed no progression of degenerative changes of the bilateral hands. The injured worker's diagnosis was noted to be arthritis of the bilateral hands status post surgery. A request was made for refill of medications. A prescription was provided for orphenadrine, gabapentin, omeprazole, and a topical analgesic. A Request for Authorization was submitted on 12/15/2014 to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orphenadrine 50mg/Caffeine 10mg, quantity: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain), Antispasmodics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics and Muscle Relaxants Page(s): 111-112, 63.

Decision rationale: The requested orphenadrine 50mg/caffeine 10mg, quantity: 60 is not medically necessary. California Medical Treatment Utilization Schedule does not recommend compounded medications. California Medical Treatment Utilization Schedule recommends short durations of treatment of muscle relaxants be limited to 2 to 3 weeks. The requested medication exceeds this recommendation. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. Additionally, there is no justification for the second component, caffeine, of this medication. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested orphenadrine 50mg/caffeine 10mg, quantity: 60 is not medically necessary.

Gabapentin/Pyridoxine 250/10mg, quantity: 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDS), Gabapentin (Neurontin).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics and Antiepilepsy drugs (AEDs) Page(s): 111-112, 16.

Decision rationale: The requested gabapentin/pyridoxine 250/10mg, quantity: 120 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend the use of compounded medications. California Medical Treatment Utilization Schedule recommends the use of anticonvulsants as a first line medication in the treatment of chronic pain. However, justification for pyridoxine was not provided. Furthermore, the request does not include a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested gabapentin/pyridoxine 250/10mg, quantity: 120 is not medically necessary.

Flurbiprofen/Omeprazole 100/10mg, quantity: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (Non-Steroidal Anti-Inflammatory Drugs) GI (Gastrointestina).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain and NSAIDs (non-steroidal anti-inflammatory drugs) and NSAIDs, GI sy.

Decision rationale: The requested flurbiprofen/omeprazole 100/10mg, quantity: 60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend compounded medications. California Medical Treatment Utilization Schedule does recommend the short term use of nonsteroidal anti-inflammatory drugs in the management of chronic pain. However, 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 injured worker's gastrointestinal system to support that they are at risk for gastrointestinal events. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested flurbiprofen/omeprazole 100/10mg, quantity: 60 is not medically necessary or appropriate.

Kera Tek gel, quantity: 113: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Non-Steroidal Antinflammatory Agents (NSAIDS).

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

Decision rationale: The requested Kera Tek gel, quantity: 113 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend the long term use of nonsteroidal anti-inflammatory drugs as topical analgesics. Additionally, there was no documentation that the injured worker has failed to respond to first line medications such as antidepressants or anticonvulsants. Furthermore, the request as it is submitted does not clearly identify a body part for application or a frequency of use. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Kera Tek gel, quantity: 113 is not medically necessary or appropriate.

Flurbiprofen/cyclo/mentherm cream 20%/10%/4%, quantity: 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Non-Steroidal Antinflammatory Agents (NSAIDS).

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

Decision rationale: The requested flurbiprofen/cyclo/mentherm cream 20%/10%/4%, quantity: 180gm is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the use of nonsteroidal anti-inflammatory drugs for short durations of treatment in a topical formulation. However, California Medical Treatment Utilization Schedule does not support the use of cyclobenzaprine in a topical formulation as there is little scientific evidence to support the efficacy and safety of this type of medication. California Medical Treatment Utilization Schedule states that any compounded medication that contains at least 1 drug or drug class that is not supported by guideline recommendations is not supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment or an applicable body part. As such, the requested flurbiprofen/cyclo/mentherm cream 20%/10%/4%, quantity: 180gm is not medically necessary or appropriate.