

Case Number:	CM15-0011605		
Date Assigned:	01/28/2015	Date of Injury:	03/07/2013
Decision Date:	03/27/2015	UR Denial Date:	01/09/2015
Priority:	Standard	Application Received:	01/20/2015

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: New York, West Virginia, Pennsylvania
Certification(s)/Specialty: Emergency Medicine

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 44 year old male, who sustained an industrial injury on 3/7/2013. He reported a back injury. Diagnoses include lumbar disc displacement without myelopathy, lumbar herniated nucleus pulposus and thoracic/lumbosacral neuritis/radiculitis. Treatments to date include physical therapy, acupuncture, injections and medication management. A progress note from the treating provider dated 12/4/2014 indicates the injured worker reported low back pain and muscle spasms. The treatment plan included Ketoprofen 20%-165 grams/cyclobenzaprine 5%-100 grams, Synapryn 10mg/1ml-500ml, Tramadol 1mg/ml-250 ml, Deprizine 15mg-250ml, Dicopanol 5mg/ml-150ml, Fanatrex 25mg/ml 420ml, shockwave therapy 3x/week for 6 weeks and lumbar spine magnetic resonance imaging. On 1/9/2015, Utilization Review non-certified the request for Ketoprofen 20%-165 grams/cyclobenzaprine 5%-100 grams, Synapryn 10mg/1ml-500ml, Tramadol 1mg/ml-250 ml, Deprizine 15mg-250ml, Dicopanol 5mg/ml-150ml, Fanatrex 25mg/ml 420ml, shockwave therapy 3x/week for 6 weeks and lumbar spine magnetic resonance imaging, citing the MTUS, ACOEM and Official Disability Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 20% 165g, Cyclobenzaprine 5% 100g: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines California Code of Regulations, Title 8 Page(s): 44-45.

Decision rationale: Topical analgesics are largely experimental and are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The requested formulation contains agents that are not supported by guidelines for topical application. The requested compounded topical cream is not medically necessary.

Synapryn 10mg/1ml Oral 500ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 71-73.

Decision rationale: Compounded medications are not recommended as a first line therapy for lumbar disc disease and muscle spasms as experienced by this patient unless a trial of first line approved drugs has been unsuccessful. In this case, there is no documentation of failure of first line medications and there is no justification for use of a compounded medication rather than an oral medication. The requested Synapryn is not medically appropriate and necessary.

Trabradol 1mg/ml 250ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Compounded medications. Decision based on Non-MTUS Citation ODG

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 71-73.

Decision rationale: Guidelines on compounded drugs do not recommend them as first line therapy but as an option after a trial of first line FDA approved drugs. In this case, there is no justification of why a compounded medication is needed rather than the standard oral formulation for treatment of lumbar disc disease pain and muscle spasms experienced by this patient. The requested Trabradol is not medically necessary and appropriate.

Deprizine 15mg 250ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Compounded medications. Decision based on Non-MTUS Citation ODG

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 71-73.

Decision rationale: Guidelines on compounded drugs do not recommend them as first line therapy but as an option after a trial of first line FDA approved drugs. In this case where this patient suffered from lumbar disc disease and muscle spasms, there is no justification of why a compounded medication is needed rather than the standard oral formulation. The requested Deprizine is not medically appropriate and necessary.

Dicopanol 5mg/ml 150ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Compounded Medications. Decision based on Non-MTUS Citation ODG

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 71-73.

Decision rationale: Guidelines on compounded drugs do not recommend them as first line therapy but as an option after a trial of first line FDA approved drugs. In this case, the patient suffered from pain associated with lumbar disc disease and muscle spasms. There is no justification of why a compounded medication is needed rather than the standard oral formulation. The request for Dicopanol was not medically appropriate and necessary.

Fanatrex 25mg/ml 420ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Compounded Medications. Decision based on Non-MTUS Citation ODG

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 71-73.

Decision rationale: Guidelines on compounded drugs do not recommend them as first line therapy but as an option after a trial of first line FDA approved drugs. In this case, there is no justification of why a compounded medication is needed rather than the standard oral formulation for treatment of the patient's pain associated with lumbar disc disease and muscle spasms. The requested Fanatrex is not medically necessary and appropriate.

Shockwave Therapy 3 x week x 6 weeks, Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines Extracorporeal Shockwave Therapy.

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

Decision rationale: Shockwave therapy has not been shown to be effective for treatment of lumbar disc disease such as that experienced by this patient. In addition, it is moderately

expensive and has short term side effects. Based on the clinical information presented, shockwave therapy is not medically necessary or appropriate.

MRI Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Lumbar and Thoracic

Decision rationale: MRI may be indicated in patients exhibiting neurologic compromise who do not respond to treatment or who show progression of a neurologic deficit. In this case, there is no documentation of the duration or progression of symptoms nor are there prior imaging studies available. The request for mri was not medically necessary and appropriate.