

<b>Case Number:</b>	CM13-0017741		
<b>Date Assigned:</b>	10/11/2013	<b>Date of Injury:</b>	06/06/2013
<b>Decision Date:</b>	07/23/2014	<b>UR Denial Date:</b>	08/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/28/2013

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 25-year-old male with a reported date of injury on 06/06/2013. The injury reportedly occurred while the injured worker was sweeping. The clinical note dated 07/02/2013 indicated the injured worker denied lower back pain, radicular pain, numbness at followup exam. The injured returned to work without difficulty and tolerating meds well. On physical examination, the injured worker's lumbar spine range of motion revealed flexion greater than 80 degrees, extension to 30 degrees, bilateral rotation to 45 degrees. In addition, the injured worker presented with negative straight leg raise. Previous physical therapy and conservative care was not provided within the documentation available for review. The clinical documentation indicated the injured worker was discharged from care to preinjury status with no heavy lifting as a restriction. The injured worker's diagnosis included lumbar strain. The medication regimen was not provided within the documentation available for review. The Request for Authorization for prescription of Deprizine (Rx 07/11/2013), prescription of Dicopanol, (Rx 07/11/2013), prescription of Fanatrex (Rx 07/11/2013), prescription of Synapryn (Rx 07/11/2013) and prescription of Tabradol (Rx 07/11/2013) was submitted on 08/23/2013. The rationale for the request was not provided within the documentation available for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PRESCRIPTION OF DEPRIZINE (RX: 07/11/13): 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 Guidelines NSAIDs, GI symptoms & Cardiovascular Risk Page(s): 68.

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) Guidelines state that clinicians should measure indications for Non-steroidal anti-inflammatory drugs (NSAIDS) against both GI and cardiovascular risk factors. To determine if the injured worker is at risk for gastrointestinal events, the documentation should include the injured worker is greater than 65 years old, history of peptic ulcer, GI bleeding and perforation, concurrent use of aspirin, corticosteroids, and/or an anticoagulant or high dose multiple NSAIDS. The California MTUS Guidelines recommend that injured workers with a risk for gastrointestinal events should utilize nonselective NSAID with either a PPI or a cox 2 selective agent. Long term PPI use has been shown to increase the risk of hip fracture. The clinical information provided for review, lacks documentation related to the injured worker's risks of gastrointestinal events. There is a lack of documentation related to the injured worker's medication regimen. The rationale is not provided within the documentation available for review. In addition, the request as submitted failed to provide the frequency, dosage and directions for use. Therefore, the request for a prescription of Deprizine (Rx 07/11/2013) is not medically necessary and appropriate.

**PRESCRIPTION OF DICOPANOL (RX: 07/11/13): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: WebMD.com.

**Decision rationale:** Dicopanol is an antihistamine. According to web MD oral Dicopanol is utilized to treat the following: Parkinson's symptoms, Parkinson's disease, extrapyramidal reaction, allergic conjunctivitis, inflammation of the nose due to an allergy, stuffy nose, itching, welt from pressure on skin, hives, sensation of spinning and whirling, chronic trouble sleeping, sneezing, cough, nausea and vomiting, feel like throwing up, throwing up, motion sickness, life threatening allergic reaction and reaction due to an allergy. The clinical information provided for review lacks documentation related to the above symptoms. The rationale for the request was not provided within the documentation available for review. In addition, the request as submitted failed to provide frequency and dosage for use. Therefore, the request for a prescription of Dicopanol (Rx 07/11/2013) is not medically necessary and appropriate.

**PRESCRIPTION OF FANATREX (RX: 07/11/13): 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 Specific Anti-Epilepsy Drugs: Gabapentin Page(s): 18.

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) Guidelines state that gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first line treatment for neuropathic pain. Clinical information provided for review, lacks documentation related to the injured worker having neuropathic pain. The clinical information lacks documentation related to the injured worker's medication regimen. In addition, the clinical note dated 07/02/2013, indicated the injured worker denied having pain, and was released back to work with restriction of not lifting more than 50 pounds. The rationale for the request was not provided within the documentation available for review. In addition, the request as submitted failed to provide frequency, dosage, and directions for use. Therefore, the request for a prescription of Fanatrex (Rx 07/11/2013) is not medically necessary and appropriate.

**PRESCRIPTION OF SYNAPRYN ( RX: 07/11/13): 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 Opioids, On-going Management Page(s): 78.

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) Guidelines recommend the ongoing management of opioids should include the ongoing review and documentation of pain relief, functional status, medication use, and side effects. Satisfactory response to treatment may be indicated by the injured worker's decreased pain, increased level of function or improved quality of life. The clinical information provided for review lacks documentation related to the injured worker's functional deficits. The clinical note dated 07/02/2013 indicated the injured worker denied having pain, and was released back to work with a restriction of no lifting greater than 50 pounds. The rationale for the request was not provided within the documentation available for review. In addition, the request as submitted failed to provide frequency, dosage and directions for use. Therefore, the request for a prescription of Synapryn (Rx 07/11/2013) is not medically necessary and appropriate.

**PRESCRIPTION OF TABRADOL ( RX: 07/11/13): 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 NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 68.

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) Guidelines states, Non-steroidal anti-inflammatory drugs (NSAIDS) are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDS appear to be superior to

acetaminophen, particularly for patients with a moderate to severe pain. For chronic back pain, NSAIDS are recommended as a second line treatment after acetaminophen. The clinical information provided for review lacks documentation related to the injured worker's medication regimen and previous physical therapy or conservative care. The clinical note dated 07/02/2013 indicates the injured worker was released back to work with a restriction of not lifting over 50 pounds. Within the clinical note, the injured worker denied low back pain, radicular pain or numbness. The rationale for the request was not provided within the documentation available for review. In addition, the request as submitted failed to provide frequency, dosage and directions for use. Therefore, the request for prescription of Tabradol (Rx 07/11/2013) is not medically necessary and appropriate.