

Case Number:	CM14-0005793		
Date Assigned:	01/29/2014	Date of Injury:	09/26/2009
Decision Date:	06/19/2014	UR Denial Date:	12/26/2013
Priority:	Standard	Application Received:	01/13/2014

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 Internal Medicine and Pulmonary Diseases and is licensed to practice in California. 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 54-year-old male who reported an injury on 09/26/2009 after he moved boxes. The injured worker's treatment history included physical therapy, chiropractic care, activity modifications, multiple medications, a lumbar brace and was monitored for aberrant behavior with urine drug screens. The injured worker was evaluated on 11/24/2014. It was documented that the injured worker had 8/10 pain of the neck and 7/10 pain of the low back. Physical findings included tenderness to palpation of the paraspinal musculature and lateral occiput with restricted range of motion secondary to pain and a positive cervical distraction and cervical compression test bilaterally. The injured worker had diminished sensation in the C5-7 dermatomal distribution with decreased motor strength secondary to pain. Evaluation of the lumbar spine documented tenderness to palpation over the lumbar musculature and right sciatic notch with limited range of motion secondary to pain and a positive tripod sign, flip test and Kemp's test bilaterally with decreased sensation in the L4, L5 and S1 dermatomes bilaterally. It was also documented that the injured worker had decreased motor strength of the bilateral lower extremities secondary to pain. The injured worker's diagnoses included cervical spine sprain/strain, cervical radiculopathy, status post carpal tunnel release, lumbar spine sprain/strain, lumbar radiculopathy, anxiety disorder, mood disorder and sleep disorder. The injured worker's treatment recommendations included continued use of medications which included Depzine, Dicopanol, Synapryn, tramadol, Cyclophene and Ketoprofen cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

DICOPANOL: 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 Official Disability Guidelines (ODG), Pain Chapter, Insomnia Treatment Section.

Decision rationale: The requested Dicopanol is not medically necessary or appropriate. The requested medication is the liquid form of diphenhydramine. The California Medical Treatment Utilization Schedule does not address this request. Official Disability Guidelines recommend sedating antihistamines for short durations of treatment as pharmacological intervention for injured workers who have sleep disturbances related to chronic pain. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's hygiene to support the need for pharmacological intervention. Additionally, there is no documentation that the injured worker has failed to respond to non-pharmacological treatments for insomnia related to chronic pain. Furthermore, the request, as it is submitted, does not provide a dosage, frequency or quantity. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Dicopanol is not medically necessary or appropriate.

FANATREX: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: The requested Fanatrex is not medically necessary or appropriate. This is a liquid compounded medication with gabapentin. The California Medical Treatment Utilization Schedule does recommend anticonvulsants as a first line treatment in the management of chronic pain. However, the clinical documentation submitted for review does not provide any evidence that the injured worker requires a liquid formulation of this medication and is not able to tolerate a traditional pill. Furthermore, the request, as it is submitted, does not clearly define a frequency, quantity or duration of treatment. Therefore, the appropriateness of the request cannot be determined. As such, the requested Fanatrex is not medically necessary or appropriate.

SYNAPRYN: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: The requested Synapryn is not medically necessary or appropriate. The requested medication is a liquid compound containing tramadol and glucosamine. The California Medical Treatment Utilization Schedule recommends glucosamine in the management of osteoarthritic pain. However, the continued use of tramadol must be supported by documentation of functional benefit, a quantitative assessment of pain relief, managed side effects and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation fails to specify why the injured worker requires a liquid formulation of these medications. Additionally, there is no quantitative assessment of pain relief or functional benefit related to the use of this medication. Furthermore, the request, as it is submitted, does not clearly identify a frequency, duration or quantity. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Synapryn is not medically necessary or appropriate.

DEPRIZINE: 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.

Decision rationale: The requested Deprizine is not medically necessary or appropriate. This medication is a liquid formulation of a nonsteroidal anti-inflammatory drug. The California Medical Treatment Utilization Schedule does recommend nonsteroidal anti-inflammatory drugs as first line medications in the management of chronic pain. However, the clinical documentation fails to address why the injured worker requires a liquid formulation and cannot tolerate a traditional pill form of this medication. Additionally, the request, as it is submitted, does not provide a frequency, duration of treatment or quantity. Therefore, the appropriateness of the request, as it is submitted, cannot be determined. As such, the requested Deprizine is not medically necessary or appropriate.