

<b>Case Number:</b>	CM14-0027116		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	01/09/2009
<b>Decision Date:</b>	07/16/2014	<b>UR Denial Date:</b>	02/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/28/2014

### 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 Occupational Medicine 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 patient is a 60 year old male who was injured on 01/09/2009 when he was hit by a moving forklift and fell to the ground. A progress report dated 01/25/2014 the patient complains of headache and pain in his forehead. The patient also complains of ringing in his ears. Objective findings in his left hand and fingers reveal decreased range of motion. Examination of the left hand exhibits normal sensation and motor reflexes and vascular pulses. Left foot examination reveals intact sensory response, motor strength, reflexes and vascular pulses. Diagnoses: Unspecified injury of the head, Post-concussion syndrome, Tinnitus, Status post trigger thumb release, Unspecified abdominal pain, Pain in unspecified ankle and joints of unspecified foot, History of crush injury of the left foot, Unspecified mood disorder, Anxiety disorder, unspecified, and Acute stress reaction. Recommendations: The patient is prescribed Deprezine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclophene and Ketoprofen cream. The patient is temporarily totally disabled. A utilization report dated indicates that the following medications were requested: Fanatrex 25 mg/ml 420 ml, Synapryn 10 mg/ml, 500 ml, Dicopanol 5 mg/ml 150 ml, Deprezine 5 mg/ml 250 ml. Regarding the Dicopanol it has been recommended as not medically necessary as there is lack of objective documentation of medication and efficacy to warrant the use of it. Furthermore, there is lack of documentation that the patient has attempted and failed pharmacological treatment prior to medication management of sleep disturbances. The request for Deprezine is recommended not medically necessary because clinical information submitted for review lacks subjective documentation indicative of dyspepsia either non-steroidal anti-inflammatory drugs or stand alone. The request for Synapryn is partially certified as the clinical records provided for review lacks subjective documentation of medication efficacy and improvement being obtained through the continued use of the requested medication. The request for Fanatrex is partially medically necessary because the clinical information provided lacked

subjective documentation suggestive of neuropathy as evidence to support the continued use of the requested medication.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **1 DICOPANOL 5MG/ML 150ML: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), MENTAL ILLNESS & STRESS, INSOMNIA TREATMENT.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), MENTAL ILLNESS & STRESS, INSOMNIA TREATMENT.

**Decision rationale:** As per ODG guidelines, Sedating antihistamines (Dicopanol/Diphenhydramine), have been suggested for sleep aid as a part of insomnia treatment. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. The guidelines state; "The specific component of insomnia should be addressed: (a) Sleep onset; (b) Sleep maintenance; (c) Sleep quality; & (d) Next-day functioning". Although the medical records document sleep disturbance in this patient, they do not provide detailed sleep study or psychological evaluation to address the cause and the component of insomnia. Moreover, there is no documentation regarding any trial of non-pharmacologic treatment. Therefore, the medical necessity of Dicopanol 5mg/ml - 150ml has not been established according to the guidelines.

#### **1 DEPRIZINE 5MG/ML 250ML: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PROTON PUMP INHIBITOR.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS & CARDIOVASCULAR RISK Page(s): 68-69.

**Decision rationale:** According to CA MTUS guidelines, Deprizine (H2-receptor antagonist) is considered in the treatment of dyspepsia secondary to NSAID administration. Although the medical records address a past medical history of ulcer, they do not document dyspepsia as a current complain. Furthermore, the patient is not documented to be treated with an oral NSAID. Therefore, the requested Deprizine 5mg/ml - 250ml is not medically necessary.

#### **1 FANATREX 25MG/ML 420: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
GABAPENTIN Page(s): 18-19.

**Decision rationale:** According to CA MTUS guidelines, Fanatrex (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. The patient has been prescribed this medication since at least 2012 as indicated by the medical records, but there is no documentation of improvement. The medical records do not address the patient's pain being of a neuropathic origin and no diagnostic study to support its presence. Therefore, the medical necessity of Fanatrex 25mg/ml - 420ml has not been established.

**1 SYNAPRYN 10MG/ML 50ML:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OPIOIDS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS  
Page(s): 78.

**Decision rationale:** According to CA MTUS guidelines, Synapryn (Tramadol) as a centrally acting Opiate analgesic is reported to be effective in managing neuropathic pain. This medication has been prescribed to the patient since at least 2012 as indicated by the records. The guidelines state the following criteria for the continuation of the ongoing treatment with opioids; "Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life". The available medical records do not document detailed assessment of the patient condition in terms of pain relief or functional improvement in response to the medication. Therefore, on the lack of documentation, the requested Synapryn 10mg/ml - 500ml is not medically necessary according to the guidelines.