

<b>Case Number:</b>	CM14-0079270		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	05/09/2006
<b>Decision Date:</b>	10/09/2014	<b>UR Denial Date:</b>	04/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/29/2014

### 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 Emergency Medicine and is licensed to practice in Texas. 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 65-year-old male who reported an injury on 05/09/2006. The mechanism of injury was not provided for clinical review. The diagnoses included cervicalgia, cervical radiculopathy, and right middle ring trigger finger, lumbar disc displacement herniated nucleus pulposus, and lumbar radiculopathy. The previous treatments included medication and physical therapy. The diagnostic testing included an MRI. Within the clinical note dated 11/05/2013, it was reported the injured worker complained of burning radicular neck pain rated 6/10 to 7/10 in severity. The injured worker also complained of radicular low back pain and muscle spasms rated 7/10 in severity. Upon physical examination, the provider noted tenderness to palpation of the suboccipital region. Range of motion was flexion at 40 degrees and extension 30 degrees. The provider noted the injured worker had tenderness on the middle and ring fingers. Sensation to pinprick and light touch was diminished over C5, C6, C7, C8, and T1 dermatomes. The provider indicated that the injured worker had tenderness to the bilateral lumbar paraspinals muscles over the spinous process at L2 and L5. The request submitted was for Synapryn, Tabradol, deprizine, Fanatrex, and dicopanolol dicopanol. However, a rationale was not provided for clinical review. The Request for Authorization was not submitted for clinical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Synapryn 10mg 500ml:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78, 93-94.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management, Page(s): 78.

**Decision rationale:** The request for Synapryn 10 mg 500 ml is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. The injured worker has been utilizing the medication since at least 11/2013. Additionally, the use of a urine drug screen was not provided for clinical review. Therefore, the request is not medically necessary.

**Tabradol 1mg/ml 250ml:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41, 64.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Page(s): 63, 64.

**Decision rationale:** The request for Tabradol 1 mg/ml 250 ml is not medically necessary. The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second line option for the short term treatment of acute exacerbations in patients with chronic low back pain. The guidelines note the medication is not recommended to be used for longer than 2 to 3 weeks. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the injured worker has been utilizing the medication since at least 11/2013 which exceeds the guideline recommendations of short term use of 2 to 3 weeks. Therefore, the request is not medically necessary.

**Deprizine 15mg/ml 250ml:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines GI symptoms & cardiovascular risk, Page(s): 68-69.

**Decision rationale:** The request for deprizine 15 mg/ml 250 ml is not medically necessary. The California MTUS Guidelines recommend that clinicians utilize the following criteria to determine if the injured worker is at risk for gastrointestinal events, including: over the age of 65; history of peptic ulcer, gastrointestinal bleeding, or perforation; or concurrent use of aspirin

or corticosteroids. The guidelines also note the medication is recommended for the treatment of dyspepsia secondary to NSAID therapy. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. Additionally, there is a lack of clinical documentation indicating the injured worker had a diagnosis of dyspepsia secondary to NSAID. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

**Fanatrex 25mg 420ml:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-22.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin, Page(s): 49.

**Decision rationale:** The request for Fanatrex 25 mg 420 ml is not medically necessary. The California MTUS Guidelines note Fanatrex has been shown to be effective for the treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered as a first line treatment for neuropathic pain. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

**Dicopanol 5mg/ml 150ml:** 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, Insomnia Treatment.

**Decision rationale:** The request for dicopanol 5 mg/ml 150 ml is not medically necessary. The Official Disability Guidelines require evaluation of sleep issues including the specific components of insomnia prior to starting pharmacological treatment. There is a lack of documentation indicating the injured worker had sleep problems or subjective complaints of insomnia. The request submitted failed to provide the frequency of the medication. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. Therefore, the request is not medically necessary.