

Case Number:	CM14-0179733		
Date Assigned:	11/04/2014	Date of Injury:	10/01/2013
Decision Date:	04/13/2015	UR Denial Date:	10/03/2014
Priority:	Standard	Application Received:	10/29/2014

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. 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 (IW) sustained an industrial injury on 10/01/2013. He reported neck pain radiating into the upper extremities and low back pain. The IW was diagnosed as having cervical spine sprain/strain, cervical radiculopathy, and lumbar spine sprain/strain. Treatment to date has included medications and activity modifications. Currently, the IW complains of burning radicular neck pain described as constant, moderate to severe and rated a 7/10. The pain is aggravated by range of motion of the head and neck and radiates to the shoulders with associated numbness and tingling of the bilateral upper extremities. The worker also complains of burning low back pain rated a 7/10 and associated with numbness and tingling of the bilateral lower extremities. The pain is aggravated by prolonged standing, sitting, walking, bending, and arising from a sitting position, ascending or descending stairs and stooping. The pain is also aggravated by daily activities including personal hygiene. Medications temporarily relieve the pain. The pain is lessened with activity restriction. On exam, the cervical spine has tenderness to palpation at the occiput, trapezius, sternocleidomastoid and levator scapula muscles. Range of motion of the cervical spine is slightly restricted; there is slightly diminished sensation in the C5, C6, C7, C8, and T1 dermatomes bilaterally. Motor strength is slightly diminished. The lumbar spine has restriction in active range of motion at 55 degrees flexion, 20 degrees extension, 20 degrees left lateral flexion, 20 degrees right lateral flexion, 20 degrees left rotation, and 20 degrees right rotation. Plans for treatment included requests for the medications Deprizine 15mg/ml oral suspension, Dicopanil (diphenhydramine) 5mg/ml Oral suspension, and for Fanatrex (gabapentin) 25ml/ml oral suspension.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro request for dicopanol (diphenhydramine) 5mg/ml Oral susp. 150ml 8/23/2014:

Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain-insomnia treatment.

Decision rationale: Retro request for dicopanol (diphenhydramine) 5mg/ml Oral susp. 150ml 8/23/2014 is not medically necessary per the ODG guidelines. The MTUS does not address insomnia or this request. There is no documentation of the necessity of taking medications in liquid form. The ODG states that pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. The documentation does not indicate that patient has had a careful evaluation of sleep disturbance or has attempted non-pharmacologic treatment/sleep hygiene. The request for Dicopanol is not medically necessary.

Retro request for fanatrex (gabapentin) 25ml/ml oral susp. 420ml 1 tsp 5ml for pain 8/23/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-18.

Decision rationale: Retro request for fanatrex (gabapentin) 25ml/ml oral susp. 420ml 1 tsp 5ml for pain 8/23/2014 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. There is no documentation of the necessity of taking medications in liquid form. The MTUS guidelines recommend Gabapentin for the treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The documentation does not indicate the necessity of taking this medication in liquid form. The request for Fanatrex is not medically necessary.

Retro request for deprizine 15mg/ml oral susp. 250ml 2tsp 10 ml OD 8/23/2014: Upheld

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

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

Decision rationale: Retro request for debrizine 15mg/ml oral susp. 250ml 2tsp 10 ml OD 8/23/2014 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. There is no documentation of the necessity of taking medications in liquid form. There is no history that patient meets MTUS criteria for a proton pump inhibitor including : (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). California Medical Treatment Utilization Schedule Chronic Pain Guidelines do not support treatment Proton Pump Inhibitor medication in the absence of symptoms or risk factors for gastrointestinal disorders. The request for Debrizine is not medically necessary.