

Case Number:	CM14-0190464		
Date Assigned:	11/21/2014	Date of Injury:	12/06/2011
Decision Date:	01/09/2015	UR Denial Date:	11/04/2014
Priority:	Standard	Application Received:	11/14/2014

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, has a subspecialty in 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 66-year-old male who reported an injury on 12/06/2011. The mechanism of injury was not provided. His diagnoses included bilateral shoulder rotator cuff tear, low back pain, other intervertebral disc displacement of the lumbar region, and lumbar spine degenerative disc disease. Past treatments were noted to include medications and extracorporeal shockwave therapy. On 03/10/2014, it was noted the injured worker had pain to his bilateral shoulders which radiated down the arms to his fingers which he rated 8/10 to 9/10. He also complained of lower back pain that radiated to the hips which he also rated 8/10 to 9/10. Upon physical examination, it was noted the injured worker had tenderness to the supraspinatus and infraspinatus muscles to the bilateral shoulders. It was also noted that he had tenderness to the paraspinal muscles, as well as decreased sensation bilaterally. The injured worker's relevant medications were not included in the report. The treatment plan was noted to include shockwave therapy, Synapryn, Tabradol, Deprizine, Dicopanol, and Fanatrex. A request was received for Synapryn 10mg/1ml/500ml, Tabradol 1mg/ml/250ml (unspecified amount), Deprizine 15mg/ml/250ml (unspecified amount), Dicopanol 5mg/ml/150ml (unspecified amount), and Fanatrex 25ml/ml (unspecified amount) without a rationale. The request for authorization was signed on 03/10/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Synapryn 10mg/1ml/500ml: 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, Criteria for Use Page(s): 78.

Decision rationale: The request for Synapryn 10mg/1ml/500ml is not medically necessary. According to the California MTUS Guidelines, ongoing use of opioids must be monitored with the direction of the 4 A's. The 4 A's for ongoing monitoring include analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. It was noted in the clinical documentation submitted for review that the injured worker had moderate to severe pain to his bilateral shoulders and lower back. However, it was not noted what his pain and activities of daily living were with and without the use of medications. A urine drug screen was not provided in order to determine medication compliance. It was noted that the injured worker did not have "any problems with medication" in terms of adverse side effects. In the absence of pain and ADLs with and without the use of medications and as a urine drug screen as not provided for review, the request is not supported by the evidence based guidelines. Additionally, the request does not specify duration or frequency of use. As such, the request for Synapryn 10mg/1ml/500ml is not medically necessary.

Tabradol 1mg/ml / 250ml (unspecified amount): 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 Muscle Relaxants (for pain) Page(s): 64.

Decision rationale: The request for Tabradol 1mg/ml/250ml (unspecified amount) is not medically necessary. According to the California MTUS Guidelines, Cyclobenzaprine is recommended for no more than 2 to 3 weeks. The clinical documentation did not note the duration of time that this injured worker had been taking this medication. Consequently, the request is not supported by the evidence based guidelines. Additionally, the request does not specify duration of treatment or frequency of use. As such, the request for Tabradol 1mg/ml/250ml (unspecified amount) is not medically necessary.

Deprizine 15mg/ml/250ml (unspecified amount): 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, GI symptoms & cardiovascular Risk Page(s): 68.

Decision rationale: The request for Deprizine 15mg/ml/250ml (unspecified amount) is not medically necessary. According to the California MTUS Guidelines, Deprizine is indicated for

those at risk for gastrointestinal events, including history of peptic ulcer or GI bleeding, concurrent use of aspirin or corticosteroid, or high dose/multiple NSAID use. The clinical documentation did not note any gastrointestinal events or a history thereof or the use of NSAIDs or aspirin to deem this request medically necessary. Therefore, the request is not supported by the evidence based guidelines. Additionally, the request does not specify duration or frequency of use. As such, the request for Deprizine 15mg/ml/250ml (unspecified amount) is not medically necessary.

Dicopanol 5mg/ml/150ml (unspecified amount): 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 5mg/ml/150ml (unspecified amount) is not medically necessary. According to the Official Disability Guidelines, the specific component of insomnia should be addressed, including sleep onset, sleep maintenance, sleep quality, and next day functioning. The guidelines also state that sedating antihistamines, such as diphenhydramine, are suggested as a sleep aid. The clinical documentation submitted for review did note that he received a restful night sleep with the use of the medications; however, the components of insomnia were not discussed. Consequently, the request is not supported by the evidence based guidelines. Additionally, the request does not specify duration and frequency of use. As such, the request for Dicopanol 5mg/ml/150ml (unspecified amount) is not medically necessary.

Fanatrex 25ml/ml (unspecified amount): 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 Antiepilepsy Drugs (AEDs) Page(s): 18.

Decision rationale: The request for Fanatrex 25ml/ml (unspecified amount) is not medically necessary. According to the California MTUS Guidelines, gabapentin is an antiepilepsy drug approved to treat post herpetic neuralgia. The clinical documentation submitted for review did not note that the injured worker had postherpetic neuralgia. Consequently, the request is not supported by the evidence based guidelines. Additionally, the request does not specify duration or frequency of use. As such, the request for Fanatrex 25ml/ml (unspecified amount) is not medically necessary.