

Case Number:	CM15-0099786		
Date Assigned:	06/02/2015	Date of Injury:	07/22/2013
Decision Date:	07/08/2015	UR Denial Date:	05/07/2015
Priority:	Standard	Application Received:	05/22/2015

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: New Jersey, New York

Certification(s)/Specialty: Family Practice

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 35 year old female, who sustained an industrial injury on 7/22/13. She reported initial complaints of low back and left shoulder and arm injuries. The injured worker was diagnosed as having headaches; cervical spine sprain/strain; cervical radiculopathy; left shoulder sprain/strain; left elbow sprain/strain; left wrist pain; lumbar sprain/strain; lumbar radiculopathy; left knee sprain/strain. Treatment to date has included shock wave therapy to left shoulder, left wrist, left elbow and left knee, cervical and lumbar spine; TENS unit; Formal Pain Evaluation (9/20/14); urine drug screening; medications. Diagnostics included MRI cervical and lumbar spine (12/4/14); MRI left knee (12/4/14); MRI left elbow and left wrist (3/26/15). Currently, the PR-2 notes dated 2/17/15 indicated the injured worker complains of occasional headaches. She complains of burning radicular neck pain and muscle spasms, greater on the left side. He pain is described as frequent to constant, moderate to severe. The injured worker rates the pain as 7/10 and is aggravated by looking up and down and side to side as well as repetitive motion of the head and neck. The left shoulder complaints are reported as burning left shoulder pain radiating down to the arm and fingers and associated with muscle spasms. She complains of an inability to mover her arm and rates the pain as 7/10. The pain is described by the injured worker as constant, moderate to severe and aggravated by gripping, grasping, reaching, pulling, lifting, and doing work above her shoulder level. The left elbow pain is described as burning pain with muscle spasms and constant moderate to severe. The pain is rated 7/10 and aggravated by gripping, grasping, reaching, pulling and lifting. She also complains of weakness, numbness, tingling and pain radiating to the hand and fingers. The low back pain is described as burning, radicular with muscle spasms rated at 7/10. It is constant,

moderate to severe and associated with numbness and tingling to the bilateral lower extremities. It is aggravated by sitting, standing, walking, bending, and arising from a sitting position, ascending, descending stairs or stooping. It is aggravated also by activities of daily living. The left knee pain is rated at 5/10 as described as constant, moderate and aggravated by normal activity of daily living. She states the pain is alleviated with medications, rest and activity restrictions. On physical examination it was revealed that she has tenderness on palpation over the spinous processes C2-C7 as well as sternocleidomastoideus muscles bilaterally. There is limited range of motion. She has tenderness to palpation at the rotator cuss as well as over the deltoid muscle with some limited range of motion in the left shoulder. The left elbow exam notes tenderness to palpation at the left cubital fossa with range of motion actively demonstrated limitations. Palpation over the carpal bones and along the distribution of the median nerve notes tenderness with some decrease to range of motion. The left knee notes tenderness to palpation over the medial and lateral joint line and to the patella-femoral joint; no instability to the anterior or posterior ligament or medial /collateral ligament. Neurological exam of the lower extremities notes decreased sensation to pin-prick and light touch at the L4, 15 and S1 dermatomes bilaterally. A MRI of the cervical and lumbar spine impression for date 12/4/14 was a C5-6, 2mm; 2.7mm at L4-5 and at L5-S1 a 2mm central disc herniation that all abuts the thecal sac. No other findings are noted. The MRI of the left knee date 12/4/14 notes "Unremarkable MRI of the left knee." The MRI of the left elbow on 3/26/15 notes "Common extensor tendinosis (lateral epicondylitis); no other significant findings are noted." The left wrist MRI was with Flexion and Extension on 3/26/15 noted a "Small subchondral cyst within the triquetrum; no other significant findings are noted." The provi der has requested a bottle of Dicopanol 5 MG/ML Oral Suspension 150 ML and a bottle of Fanatrex 25 MG/ML Oral Suspension 420 ML.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bottle of Dicopanol 5 MG/ML Oral Suspension 150 ML: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy Drugs Page(s): 17-18.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Diphenhydramine (benadryl).

Decision rationale: The request is considered not medically necessary. As per ODG guidelines, it is not recommended, especially for long-term treatment for insomnia. Alternative treatments are recommended. Sleep hygiene should be discussed. Also, there is no indication that the patient is unable to tolerate tablets or capsules and requires an oral suspension. Therefore, the request is considered not medically necessary.

Bottle of Fanatrex 25 MG/ML Oral Suspension 420 ML: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anticonvulsants, Gabapentin Page(s): 16-19, 49.

Decision rationale: The request is not medically necessary. Gabapentin is an anti-epilepsy drug that is effective for neuropathic pain. The patient has chronic cervical and lumbar radiculopathy and would benefit from gabapentin. However, there is no indication as to why an oral suspension is required, if the patient cannot tolerate tablets or capsules. Therefore, the request for Fanatrex is considered not medically necessary.