MAXIMUS Federal Services

Case Number:	CM13-0065104		
Date Assigned:	01/03/2014	Date of Injury:	02/21/2009
Decision Date:	06/04/2014	UR Denial Date:	12/03/2013
Priority:	Standard	Application Received:	12/12/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain 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 53-year-old female who was injured on 02/21/2009. The mechanism of injury is unknown. The progress note dated 11/05/2013, documented the patient to have complaints of burning radicular low back pain and muscle spasms. She rates the pain as 6-7/10 on a pain analog scale. It is associated with occasional to frequent numbness and tingling of the bilateral lower extremities. She states that she has difficulty getting out of the bath tub by herself. The patient denies any bowel or bladder problems. Objective findings on exam included an examination of the lumbar spine, revealing that the patient is able to do heel-toe walk; however, with pain in the lower back. There is tenderness to palpation to the lumbar paraspinal musculature, bilaterally associated with bilateral muscle guarding. The clinical examination revealed limitation of movements and impaired sensations of the lower extremities. The diagnoses included: 1. Lumbar spine herniated nucleus pulposus (HNP) 2. Lumbar radiculopathy 3. Anxiety Disorder 4. Mood Disorder 5. Sleep Disorder Recommendations: The patient was prescribed the following medications: 1. Deprizine 2. Dicopanol 3. Fanatrex 4. Synapryn 5. Cyclophene 6. Ketoprofen Cream Additionally, to my knowledge, there are no conditions that will impede or delay the patient's recovery.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE PRESCRIPTION OF SYNAPRYN 10MG/1ML 500ML #1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, AND THE NATIONAL GUIDELINE CLEARINGHOUSE.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOID FOR CHRONIC PAIN Page(s): 80.

Decision rationale: The Chronic Pain Guidelines indicate that Synapryn (contains Tramadol and Glucosamine). Tramadol is an opioid, and appears to be effective, but is limited for short-term pain relief. Long-term effectiveness is unclear (>16 weeks), but also appears to be limited. The medical records do not document if the patient started the Synapryn before, and if so on what date. The medical records do not provide a clear rationale indicating why this patient requires a compounding kit versus a traditional off the shelf formulation of Tramadol and/or Glucosamine. There is a lack of evidence that indicates that the patient would benefit from Glucosamine, as there is no diagnosis of osteoarthritis. Therefore, in the lack of documentation on usage, Synapryn is not medically necessary according to the guidelines.