

Case Number:	CM14-0005534		
Date Assigned:	01/24/2014	Date of Injury:	06/17/2012
Decision Date:	06/20/2014	UR Denial Date:	12/25/2013
Priority:	Standard	Application Received:	01/13/2014

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 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 37 year old female who was injured on 06/17/2012 while she sustained a cumulative trauma of injuries to the low back and bilateral knees while she was performing her regular work duties as a nurse assistant. Prior treatment history has included physiotherapy and chiropractic treatment. Diagnostic studies reviewed include urine drugs screen dated 06/24/2013 resulting in a negative report for no drug prescribed. On 08/12/2013 and 09/23/2013 urine drug screens were negative for all drugs tested and are consistent with prescribed medications as listed. Progress report dated 09/23/2013 documented the patient with complaints of burning, radicular neck pain and muscle spasms. Her pain is described as constant moderate to severe and rated 5/10. She complains of burning, radicular low back pain and muscle spasms and rates the pain at 4/10 being intermittent to frequent, mild to moderate. The pain is associated with radiating pain, numbness and tingling of the bilateral lower extremities. The patient denies any bladder or bowel problems. Objective findings on examination reveal tenderness to palpation at the suboccipital region, trapezius and the scalene muscles. Range of motion of the cervical spine reveals flexion 45 degrees, extension 55 degrees, left and right rotation 75 degrees and left and right lateral flexion 40 degrees. Sensation to pinprick and light touch is intact over all dermatomes bilaterally. Motor strength is reduced bilaterally secondary to pain. DTRs are 2+ in the bilateral upper extremities. Examination of the lumbar spine reveals palpable tenderness is noted over the lumbar paraspinal muscles and over the lumbosacral junction. Range of motion of the lumbar spine is flexion 50 degrees, extension, left and right lateral flexion 20 degrees, and left and right rotation 25 degrees. Straight leg raise is bilaterally positive at 60 degrees. Recommendations: The patient was prescribed the medications listed below: Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclophene, Ketoprofen cream. The patient is recommended to continue the course of physiotherapy and chiropractic treatment for the affected

body parts in frequency of 3 times per week for a period of six weeks. UR report dated 12/25/2013 denied the request for Synapryn as this drug has not been found by the FDA to be safe and effective and the FDA has not approved this labeling. Tabradol has been denied because it contains Methylsulfonylmethane, which is not FDA approved. Deprizine has been denied because there is no report of peptic ulcer disease that would indicate a need for a H2 blocker. In addition, there is no rationale provided for the medical necessity of an oral suspension. Dicopanol has been denied because there are no clinical findings such as insomnia that would support the use of antihistamine. In addition, there is no rationale provided for the medical necessity of an oral suspension. Fanatrex was denied because there is no rationale provided for the medical necessity of an oral suspension.

IMR ISSUES, DECISIONS AND RATIONALES

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

SYNAPRYN 10 MG/ML ORAL SUSPENSION, 500 ML: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Food and Drug Administration (FDA).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines , Tramadol (Ultram), Page(s): 113.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. The medical records document the patient was diagnosed with cervical spine pain with radiculopathy, and lumbar spine pain with radiculopathy the patient was on this medication since 3/2/2013. In the absence of documented significant improvement of pain and function and in the absence of clinical indication of oral suspension form for this patient, the request is not medically necessary according to the guidelines

TABRADOL 1 MG/ML ORAL SUSPENSION, 250 ML: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Cyclobenzaprien (Flexeril). Page(s): 41-42.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine is recommended as an option, using a short course of therapy. The addition of Cyclobenzaprine to other agents is not recommended. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system (CNS) depressant. The medical records document the patient was diagnosed with cervical spine pain with radiculopathy, and lumbar spine pain with radiculopathy the patient was on this medication since 3/2/2013. This is significantly longer than the recommended use, which is 2-3 weeks. In the absence of documented significant improvement of pain and function and in the absence of clinical indication of oral suspension

form for this patient, further, using this medication with opioid medication it can potentiate the central nervous system depressant effect. Therefore, the request is not medically necessary according to the guidelines.

DEPRIZINE 15 MG/ML ORAL SUSPENSION, 250 ML: 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 Chronic Pain Medical Treatment Guideline,(NSAIDS non-steroidal anti-inflammatory drugs), GI Sym.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, H2-receptor is recommended in the treatment of dyspepsia secondary to NSAID therapy. The medical records document the patient was diagnosed with cervical spine pain with radiculopathy, and lumbar spine pain with radiculopathy the patient was on this medication since 3/2/2013. In the absence of documented dyspepsia or any other GI events, the request is not medically necessary according to the guidelines.

DICOPANOL 5 MG/ML ORAL SUSPENSION, 150 ML: 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 CA MTUS guidelines have not addressed the issue of dispute. According to the ODG, insomnia medication should only be used after careful evaluation of potential causes of sleep disturbance. The medical records document the patient was diagnosed with cervical spine pain with radiculopathy, and lumbar spine pain with radiculopathy the patient was on this medication since 3/2/2013. In the absence of documented insomnia components which are sleep onset, sleep maintenance, sleep quality, and secondary insomnia, and trial of sleep hygiene, the request is not medically necessary according to the guidelines.

FANATREX 25 MG/ML ORAL SUSPENSION, 420 ML: 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 Chronic Pain Medical Treatment Guidelines , Antiepilepsy Drugs (AEDS). Page(s): 16-17.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, Gabapentin is recommended as a first-line therapy for painful polyneuropathy (with diabetic polyneuropathy

being the most common example). The medical records document the patient was diagnosed with cervical spine pain with radiculopathy, and lumbar spine pain with radiculopathy the patient was on this medication since 3/2/2013. In the absence of documented significant improvement of pain and function and in the absence of clinical indication of oral suspension form for this patient, the request is not medically necessary according to the guidelines.