

<b>Case Number:</b>	CM14-0113141		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	04/12/2011
<b>Decision Date:</b>	10/03/2014	<b>UR Denial Date:</b>	06/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/21/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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:

This is a female patient with a date of injury of April 12, 2011. A utilization review determination dated June 26, 2014 recommends non-certification of Tabradol 1mg/ml #250ml, Synapryn 10mg/ml #250ml, and Deprizine 15mg/ml #250ml. A progress note dated January 2, 2014 does not contain subjective complaints, physical examination, or list of diagnoses. The treatment plan recommends prescriptions for Dicopanol 5mg/ml #150ml, Deprizine 5mg/ml #250ml, Fanatrex 25mg/ml #420ml, Synapryn 10mg/ml #500ml, and Tabradol 1mg/ml #250ml.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tabradol 1mg/ml, #250ml:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82, 93, 94.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines non-sedating muscle relaxants Page(s): 63-66 of 127.

**Decision rationale:** Regarding the request for Tabradol, Tabradol contains cyclobenzaprine hydrochloride 1 mg/ml, in oral suspension with MSM - compounding kit. Regarding cyclobenzaprine, Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of

acute exacerbations of pain. Guidelines go on to state that cyclobenzaprine specifically is recommended for a short course of therapy. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the cyclobenzaprine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested Tabradol is not medically necessary.

**Synapryn 10mg/ml, #250ml:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82, 93, 94, 50.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 50 and 75-79 of 127. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence:  
<http://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=22416>

**Decision rationale:** Regarding the request for Synapryn 10mg/ml, #250ml, this compound is noted to contain tramadol and glucosamine. With regard to opioids such as tramadol, California MTUS Chronic Pain Medical Treatment Guidelines state that, due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. With regard to glucosamine, it is recommended as an option in patients with moderate arthritis pain, especially for knee osteoarthritis. Within the documentation available for review, there is no indication that the medication is improving the patient's pain (in terms of percent reduction in pain or reduced NRS), no discussion regarding aberrant use, no documentation of knee osteoarthritis, and no clear rationale for the use of this oral suspension compounded kit rather than the FDA-approved oral tablet forms. In the absence of such documentation, the currently requested Synapryn 10mg/ml, #250ml is not medically necessary.

**Deprizine 15mg/ml, #250ml:** 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 Page(s): 68-69 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Proton Pump Inhibitors (PPIs) and Other Medical Treatment Guideline or Medical Evidence: <http://www.drugs.com/pro/deprizine.html>.

**Decision rationale:** Regarding the request for Deprizine 15mg/ml, #250ml, Deprizine contains active and inactive bulk materials to compound a ranitidine hydrochloride oral suspension. California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is no indication that the patient

has complaints of dyspepsia secondary to NSAID use, has a risk for gastrointestinal events with NSAID use, or another indication for this medication. In light of the above issues, the currently requested Deprizine 15mg/250ml is not medically necessary.