

<b>Case Number:</b>	CM14-0119330		
<b>Date Assigned:</b>	09/24/2014	<b>Date of Injury:</b>	09/19/2012
<b>Decision Date:</b>	11/18/2014	<b>UR Denial Date:</b>	07/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/29/2014

### 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 Interventional Spine 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 42 years old male with an injury date on 09/19/2012. Based on the 04/14/2014 progress report provided by [REDACTED], the diagnoses are: 1. Headaches 2. Inguinal pain, left side, improved 3. Low back pain 4. Lumbar spine radiculopathy According to this report, the patient complains of headaches, pain at the left inguinal region, and radicular low back pain with spasm. "Headaches are more often than ever before, and he is having them three times a week." Pain in the low back is rated as an 8/10 that is "constant, moderate to severe." The pain is "aggravated by prolonged positing including sitting, standing, walking, bending, arising from sitting positing, ascending or descending stair, and stooping." The pain is also "aggravated by activities of daily living such as getting dressed and performing personal hygiene." Patient states "medications do offer her temporary relief of pain and improve her ability to have restful sleep." Physical exam reveals tenderness at the lumbar paraspinal muscles and over the lumbosacral junction. Range of motion is restricted. Straight leg raise is positive, bilaterally. Decreased sensation to pin prick and light touch at the L4, L5, and S1 dermatomes bilaterally. L2, L3, L4, L5, and S1 myotomes are decreased bilaterally. There were no other significant findings noted on this report. The utilization review denied the request on 07/01/2014. [REDACTED] is the requesting provider, and he provided treatment reports from 03/14/2013 to 05/02/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RETRO 5/12/14 Deprizine 5mg/ml 250ml #1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmed/2712050>

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PPI: NSAIDs, GI symptoms & cardiovascular risk Page(s): 69.

**Decision rationale:** According to the 04/14/2014 report by [REDACTED] this patient presents with headaches, pain at the left inguinal region, and radicular low back pain with spasm. Patient's current medications are Fanatrex, Synapryn, Dicopanol, Tabradol, Flurbiprofen and Capacin. The treater is requesting a retro 5/12/2014 of Deprizine (Ranitidine) 5mg/mL 250ml, #1. Deprizine was first mentioned in the 12/11/2013 report; it is unknown exactly when the patient initially started taking this medication. The MTUS Guidelines state PPI's are recommended for patients at risk for gastrointestinal events if used prophylactically for concurrent NSAIDs. MTUS requires proper GI assessment such as the age, concurrent use of anticoagulants, ASA, history of PUD, gastritis, etc. Review of the reports show that the patient is taking Flurbiprofen and has no gastrointestinal side effects with medication use. There is no discussion regarding GI assessment as required by MTUS. MTUS does not recommend routine use of GI prophylaxis without documentation of GI risk. In addition, the treater does not mention symptoms of gastritis, reflux or other condition that would require a medication such as Ranitidine. Therefore, Retro 5/12/14 Deprizine 5mg/ml 250ml #1 is not medically necessary.

**RETRO 5/12/14 Fanatrex 25mg/ml 420ml #1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18-19.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain (MTUS 60,61) Gabapentin (Neurontin) Page(s): 18, 19 AND 49.

**Decision rationale:** According to the 04/14/2014 report by [REDACTED] this patient presents with headaches, pain at the left inguinal region, and radicular low back pain with spasm. The treater is requesting a retro 5/12/2014 of Fanatrex 25mg/ml 420ml #1. Fanatrex was first mentioned in the 12/06/2013 report; it is unknown exactly when the patient initially started taking this medication. Regarding Anti-epileptic (AKA anti-convulsants) drugs for pain, ODG Guidelines recommend for neuropathic pain (pain due to nerve damage), but not for acute somatic pain. Review of reports indicates that the patient has neuropathic pain. The ODG guidelines support the use of anti-convulsants for neuropathic pain. However, the treater does not mention that this medication is working. There is no discussion regarding the efficacy of the medication. MTUS page 60 require that medication efficacy in terms of pain reduction and functional gains must be discussed when used for chronic pain. Therefore, Retro 5/12/14 Fanatrex 25mg/ml 420ml #1 is not medically necessary.

**RETRO 5/12/14 Synapryn 10mg/ml 500ml #1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-78, 93, 94.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines chronic pain CRITERIA FOR USE OF OPIOIDS CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 60,61, 88.

**Decision rationale:** According to the 04/14/2014 report by [REDACTED] this patient presents with headaches, pain at the left inguinal region, and radicular low back pain with spasm. The treater is requesting a retro 5/12/2014 of Synapryn 10mg/ml 500ml. Synapryn (Tramadol) was first mentioned in the 12/06/2013 report; it is unknown exactly when the patient initially started taking this medication. For chronic opiate use, MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and aberrant behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In this case, pain assessment using a numerical scale describing the patient's pain as an 8/10 that is "constant, moderate to severe." A detailed list of ADL's were provided stating pain "aggravated by activities of daily living such as getting dressed and performing personal hygiene." Patient states "medications do offer her temporary relief of pain and improve her ability to have restful sleep." However, no outcome measures are provided; No aberrant drug seeking behavior is discussed, and no discussion regarding side effects. There is no opiate monitoring such as urine toxicology. Given the lack of sufficient documentation demonstrating efficacy from chronic opiate use, the patient should be slowly weaned as outlined in MTUS Guidelines. Therefore, Retro 5/12/14 Synapryn 10mg/ml 500ml #1 is not medically necessary.

**RETRO 5/12/14 Dicopanol 5mg/ml 150ml #1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG) mental illness under Diphenhydramine (Benadryl)

**Decision rationale:** According to the 04/14/2014 report by [REDACTED] this patient presents with headaches, pain at the left inguinal region, and radicular low back pain with spasm. The treater is requesting a retro 5/12/2014 of Dicopanol 5mg/ml 150ml #1. Dicopanol is diphenhydramine 5mg/ml in an oral suspension with other proprietary ingredients. Regarding diphenhydramine, ODG guidelines state "sedating antihistamines are not recommended for long-term insomnia treatment. The AGS updated Beers criteria for inappropriate medication use includes diphenhydramine. (AGS, 2012)." Review of reports does not show the patient has sleeping issue. In this case, the treater is requesting Dicopanol and this medication was first noted in the 12/13/2013 report. Dicopanol is not recommended for long term use. The treater

does not mention that this is for a short-term use. Therefore, Retro 5/12/14 Dicopanol 5mg/ml 150ml #1 is not medically necessary.