MAXIMUS Federal Services

Case Number:	CM14-0126717		
Date Assigned:	08/13/2014	Date of Injury:	03/02/2011
Decision Date:	09/11/2014	UR Denial Date:	08/11/2014
Priority:	Standard	Application Received:	08/11/2014

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 Neuromuscular Medicine and is licensed to practice in Maryland. 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 49 year old female with a work injury dated 3/2/11. The diagnoses include headaches; facial pain; sprain of the ligaments of the cervical spine; cervical radiculopathy, thoracic disc displacement, lumbar radiculopathy, bilateral hip pain, anxiety and mood disorders, nonorganic sleep disorder. Under consideration is a request for: Synapryn; Tabradol; Deprizine; Dicopanol; Fanatrex.There is a primary treating physician report dated 2/11/14 that states that the patient has headaches, burning radicular neck pain 8/10; burning radicular mid back pain; burning radicular low back pain; burning bilateral hip pain rated as a 5-6 on the pain scale. She has stress, anxiety and difficulty sleeping. The patient states that her symptoms persist but the medications offer temporary relief and improve her ability to have restful sleep. She denies any problems with the medications. On physical exam of the cervical spine there are tender suboccipital and trapezii. There is decreased range of motion. The thoracic exam reveals bilateral paraspinal tenderness and decreased range of motion. The lumbar spine revealed paraspinal tenderness. There is decreased range of motion and a positive straight leg raise. Both the cervical and lumbar spine exam note decreased sensation and "decreased myotomes bilaterally." The plan includes internal medicine consult, therapies, and medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Synapryn 10mg/1ml # 500ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain. Decision based on Non-MTUS Citation ODG- Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram)-p.113; On-Going Management Page(s): 113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain- Glucosamine (and Chondroitin sulfate).

Decision rationale: Synapryn contains tramadol and glucosamine, as well as other proprietary ingredients. Synapryn was prescribed for pain. The MTUS states that Tramadol is not recommended as a first line analgesic. The documentation submitted is not clear on patient's ongoing review and documentation of pain relief, functional status and on-going medication management or treatment plan. There is no indication that the patient needs glucosamine for knee arthritis. There is no indication that patient requires liquid over pill form of medication. There is no indication that the patient has failed oral pill form first line medications prior to Tramadol. The ODG states that glucosamine is recommended as an option (glucosamine sulfate only) given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis . Synapryn is not medically necessary is not medically necessary and appropriate.

Tabradol 1mg/ml # 25ml: 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 Cyclobenzaprine Page(s): 41-42.

Decision rationale: Tabrodol contains Cyclobenzaprine, Methylsulfonylmethane and other proprietary ingredient. The MTUS states that Cycobenzaprine treatment should be brief with short course of therapy. Additionally the MTUS states that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence.The documentation does not reveal exam findings of spasm. There is no documentation of why the patient cannot take pill over liquid form of medications.Tabrodol is not medically necessary and appropriate.

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 NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: Deprizine contains ranitidine and other proprietary ingredients.Ranitidine is an H2 blocker. Ca MTUS does not specifically address H2 blocker, however the California MTUS guidelines recommend the use of proton pump inhibitors for patients taking NSAIDs who are at risk for gastrointestinal events such as patients who are over the age of 65, have a history

of a peptic ulcer, Gastrointestinal (GI) bleeding, or perforaton; concommitent use of aspirin, corticosteroids, and/or an anticoagulant, or high dose/multiple NSAID use. There is no documentation stating the patient has one of the above risk factors. There is no indication why the patient cannot take an oral pill or capsule. The request for Deprizine 15mg/ml 250ml is not medically necessary or appropriate.

Dicopanol 15mg/ml # 150ml: 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 (Chronic) , Insomnia treatment.

Decision rationale: The MTUS does not specifically mention treatment for insomnia. The ODG states that Dicopanol was prescribed for insomnia and contains Diphenhydramine. The ODG states that sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine). Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function There is no documentation of a discussion of sleep hygiene with the patient. There is no indication that the patient cannot take pill form of medications. The request for Dicopanol 15MG/ML oral suspension, 150ML is not medically necessary and appropriate.

Fanatrex 25mg/ml # 120ml: 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 Gabapentin, Functional Restoration Approach to Chronic Pain Management Page(s): 49; 7-8.

Decision rationale: Fanatrex contains Gabapentin and other proprietary ingredients. The documentation submitted does not indicate why patient cannot take the oral form of this medication. Fanatrex 25mg/ml oral suspension would be medically inappropriate. The request for Fanatrex is not medically necessary and appropriate.