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| <b>Case Number:</b>   | CM14-0051976 |                              |            |
| <b>Date Assigned:</b> | 07/21/2014   | <b>Date of Injury:</b>       | 03/31/2006 |
| <b>Decision Date:</b> | 09/08/2014   | <b>UR Denial Date:</b>       | 04/14/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 04/21/2014 |

### 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, and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 46 year old female was reportedly injured on March 31, 2006. The mechanism of injury is undisclosed. The most recent progress note, dated March 19, 2014, indicated that there were ongoing complaints of low back pain. The physical examination demonstrated 5'3", 120 pound individual who is normotensive, slight antalgic gait pattern was reported, deep tendon reflexes for both lower extremities were noted to be bilaterally normal, and there was no motor loss or sensory loss identified in the lower extremities. Diagnostic imaging studies were not reviewed. Previous treatment included multiple medications, acupuncture, physical therapy, chiropractic care, and other conservative interventions were also noted. A request was made for multiple medications and was not certified in the pre-authorization process on April 14, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Synapryn 10mg/1ml Oral suspension, 500ml.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Combination medication.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 82, 113 of 127.

**Decision rationale:** This medication is also known as Tramadol, a centrally acting synthetic opioid analgesic. This is not recommended as a first line treatment. The progress notes presented for review note ongoing complaints of pain; however, there is no data presented of them asserting their relative efficacy or utility of the use of this second line opioid analgesic. Therefore, the medical necessity for the continued use of this medication has not been established.

**Tabradol 1mg/ml Oral suspension, 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 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009): Muscle relaxants Page(s): 41, 64 of 127.

**Decision rationale:** The detailed progress notes, presented for review, indicated that there were ongoing complaints of low back pain and some muscle spasm. What is not noted in the progress notes is if that there is any efficacy or utility with the medications being prescribed. Furthermore, as outlined in the Medical Treatment Utilization Schedule (MTUS), this medication is not for the indefinite or chronic treatment for myofascial low back pain. Therefore, based on the progress notes presented for review and by the parameters noted in the MTUS, this medication is not medically necessary.

**Deprizine 15mg/ml Oral suspension, 250ml.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 68 of 127.

**Decision rationale:** This is a compounded oral suspension preparation for a proton pump inhibitor. The standards for a proton pump inhibitor are applied. The progress notes do not indicate any particular complaints of gastritis, gastroesophageal reflux disease, or any other symptoms relative to the gastroesophageal (GI) tract. Therefore, the medical necessity for this medication has not been established.

**Dicopanol 5mg/ml Oral suspension, 150ml.:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Integrated Treatment,/Disability Duration Guidelines, Pain (chronic) - Insomnia treatment.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 65 of 127.

**Decision rationale:** Dicopano (diphenhydramine) is an oral suspension compounded medication to treat allergic reactions, motion sickness, and symptoms of Parkinson's disease. This medication is basically an antihistamine. The parameters for antihistamines are not applicable in this clinical situation. Based on the medical records presented for review, there is no clinical indication for such a medication, and furthermore, when noting the pain complaints are unchanged, the efficacy of this preparation has not been established. Therefore, this request is considered not medically necessary.

**Fanatrex 25mg/ml Oral suspension, 420ml.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 .MTUS (Effective July 18, 2009) Page(s): 16-18 of 127.

**Decision rationale:** This medication is an oral suspension compounded medication. Gabapentin is primarily indicated to treat seizures, and an off label use has been noted to address neuropathic pain lesion. There is no noted post herpetic neuralgia or specific neuropathic lesion identified. Furthermore, the progress notes did not demonstrate any efficacy or utility. Therefore, the medical necessity for continued use of this failed product is not presented.