

<b>Case Number:</b>	CM14-0081408		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	02/27/2013
<b>Decision Date:</b>	08/25/2014	<b>UR Denial Date:</b>	05/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/02/2014

### 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 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 32 year old female with date of injury 2/27/13. The mechanism of injury is stated as injury while performing her usual duties as a cook. The patient has complained of neck pain and right upper extremity pain since the date of injury. She has been treated with physical therapy and medications. MRI of the cervical spine performed in 11/2013 revealed disc disease at C2-7, disc herniation at C4-5 with spinal stenosis at this level and disc herniation at C5-6. MRI of the right wrist performed in 11/2013 was normal. Objective: tenderness to palpation at the right occiput, scalene and sternocleidomastoid muscles, decreased and painful range of motion of the cervical spine, right AC joint tenderness to palpation, decreased right shoulder range of motion, decreased range of motion of the right wrist. Diagnoses: cervical spine disc disease, right shoulder sprain, right elbow pain, right wrist pain. Treatment plan and request: Dicopanol, Deprizine, Fanatrex, Synapryn, Tabradol.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Dicopanol 5mg/ml:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/pro/dicopanol.html>.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: [www.drugs.com/pro/dicoprofanol](http://www.drugs.com/pro/dicoprofanol).

**Decision rationale:** There is no specific MTUS guideline regarding Dicoprofanol. Per the reference cited above under Other Medical Treatment Guideline, Dicoprofanol is an antihistamine suspension (diphenhydramine) used to treat allergic rhinitis and motion sickness and may also be used to induce sleep. There is no specific indication or recommendation per evidenced based guidelines for use of this medication in chronic musculoskeletal pain. There are no diagnoses listed in the available medical records which support the use of this medication and no documentation regarding the specific need for a suspension formulation. On the basis of current evidenced based medical guidelines and the available documentation, Dicoprofanol is not medically necessary.

**Deprizine 5mg/ml:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/pro/deprizine.html>.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: [www.drugs.com/pro/deprizine](http://www.drugs.com/pro/deprizine).

**Decision rationale:** There is no specific MTUS guideline regarding Deprizine. Per the reference cited above under Other Medical Treatment Guideline, Deprizine is an oral suspension of ranitidine and used to treat symptoms of heartburn and gastroesophageal reflux related disease. There is no documentation in the available medical records of gastroesophageal symptomatology nor is there a medical rationale regarding the necessity of delivery of the medication in an oral suspension. On the basis of the above cited medical treatment guideline and the available provider documentation, Deprizine is not indicated as medically necessary.

**Fanatrex 25mg/ml:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/pro/fanatrex.html>.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epileptic drugs, page 49 Page(s): 49.

**Decision rationale:** Per the MTUS guideline cited above, gabapentin is an anti-epileptic agent recommended to treat diabetic painful neuropathy and post herpetic neuropathy. There is no documentation in the available medical records that supports the presence of any of these medical conditions. On the basis of this lack of documentation, Fanatrex is not indicated as medically necessary.

**Synapryn 10mg, 1ml:** Upheld

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

<http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=594bad96-d0e0-4a12-8a38-762962f54a66SYNAPRYN>.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, pages 76-85, 88-89 Page(s): 76-85, 88-89.

**Decision rationale:** Per the MTUS guideline cited above, No treating physician reports adequately assess the patient with respect to function, specific benefit, return to work, signs of abuse or treatment alternatives other than opioids. There is no evidence that the treating physician is prescribing opioids according to the MTUS section cited above which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, opioid contract and documentation of failure of prior non-opioid therapy. On the basis of this lack of documentation and failure to adhere to the MTUS guidelines, Synapryn is not indicated as medically necessary.

**Tabradol 1mg/ml:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, <http://www.drugs.com/cons/fusepaq-trabradol.html>.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, pages 41-42 Page(s): 41-42.

**Decision rationale:** This 32 year old female has complained of neck pain and right upper extremity pain since the date of injury 2/27/13. She has been treated with physical therapy and medications to include Tabradol, an oral suspension of cyclobenzaprine, since at least 06/2013. Per MTUS guidelines, treatment with cyclobenzaprine should be reserved as a second line agent only and should be used for a short course (2 weeks) only, and the addition of cyclobenzaprine to other agents is not recommended. On the basis of the cited MTUS guidelines, Tabradol is not indicated as medically necessary.