

<b>Case Number:</b>	CM15-0105324		
<b>Date Assigned:</b>	06/16/2015	<b>Date of Injury:</b>	01/06/2014
<b>Decision Date:</b>	09/22/2015	<b>UR Denial Date:</b>	05/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/01/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: New York, West Virginia, Pennsylvania  
 Certification(s)/Specialty: Emergency Medicine

### 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 43 year old male sustained an industrial injury to the eye, left shoulder, right knee, right ankle and back on 1/6/14. Previous treatment included magnetic resonance imaging, physical therapy, acupuncture, chiropractic therapy, epidural steroid injections and medications. In the most recent documentation submitted for review, a PR-2 date 1/25/15, the injured worker complained of pain in the left eye, left shoulder with radiation down the arm to the fingers, low back, right knee associated with numbness, tingling and radiation to the foot and right ankle. The injured worker rated his pain 5-6/10 on the visual analog scale. The injured worker stated that the medications offered him temporary relief of pain and improved his ability to have restful sleep. Physical exam was remarkable for tenderness to palpation to the left shoulder with arthrosis on the acromial joint, decreased range of motion and positive Neer's, Kennedy Hawkin's and Speed's tests, lumbar spine with tenderness to palpation and decreased range of motion and right knee with tenderness to palpation with decreased range of motion and positive Apley's test without evidence of instability. Current diagnoses included resolving eye injury, left shoulder pain, left shoulder internal derangement, low back pain, lumbar spine herniated nucleus pulposus, right knee subcortical cyst, internal derangement right knee, right ankle pain, mood disorder, anxiety, stress and sleep disorder. The treatment plan included medications (Synapryn, Tabradol, Deprizine, Dicopanil and Fanatrex).

### 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, 5ml three times a day or as directed by your physician for pain, unresponsive to first line treatment: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids/Topical analgesics Page(s): 74-96, 111-113.

**Decision rationale:** Guidelines do not recommend Synapryn as a first line therapy but may be recommended as an option after a trial of first line therapy has failed. In this case, there is no documentation of the failure of first line approved drugs and there is no justification for use of a compounding kit. In addition, opioids are recommended to treat moderate to severe pain as long as there is a positive response in pain and functioning, which in this case, there was not. The request for Synapryn is not medically necessary and appropriate.

**Tabradol 1mg/ml oral suspension 250ml 5ml two-three times a day or as directed by your physician for muscle spasm: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42, 63, 37-38.

**Decision rationale:** Guidelines do not recommend Tabradol compound as a first line therapy but may be an option after first line therapy has failed. In this case, there is no justification for use of a compounding kit instead of the standard oral form and guidelines do not recommend sedating muscle relaxants for long-term use, rather for acute exacerbations. Documents do not indicate acute pain or an acute exacerbation of chronic pain. The request for Tabradol 1mg/ml #250 ml is not medically appropriate and necessary.

**Deprizine 15mg/ml oral suspension 250ml 10ml once daily or as directed by your physician for GI pain and as a prophylaxis against development of gastric ulcer: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

**Decision rationale:** Guidelines do not recommend compound drugs as first line therapy but may be an option after a trial of first line drugs. In this case, there is no justification for use of a compounding kit instead of the standard oral/off the shelf formulation. There also is no

documentation of gastrointestinal issues to support use of this medication. The request for Deprizine is not medically appropriate and necessary.

**Fanatrex (gabapentin) 25mg/ml oral suspension 420ml, 5ml tid or as directed by your physician for chronic neuropathic pain: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs.

**Decision rationale:** Guidelines do not recommend compound drugs as first line therapy but may be an option after a trial of first line drugs. In this case, there is no justification for use of a compounding kit instead of the standard oral/off the shelf formulation. The request for Fanatrex is not medically appropriate and necessary.

**Dicopanor (diphenhydramine) 5mg/ml oral suspension 150ml, 1 ml po at bedtime , may increase as tolerated to a max of 5ml ud by MD for insomnia: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Compound drugs.

**Decision rationale:** Guidelines do not recommend compound drugs as first line therapy but may be an option after a trial of first line drugs. In this case, there is no justification for use of a compounding kit instead of the standard oral/off the shelf formulation. There also is no documentation of insomnia issues to support use of this medication. The request for Dicopanor is not medically appropriate and necessary.