

Case Number:	CM15-0136333		
Date Assigned:	07/27/2015	Date of Injury:	05/09/2014
Decision Date:	09/23/2015	UR Denial Date:	06/12/2015
Priority:	Standard	Application Received:	07/14/2015

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: California, Massachusetts
 Certification(s)/Specialty: Preventive Medicine, Occupational 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:

The injured worker (IW) is a 53-year-old female who sustained an industrial injury 05/09/2014. Diagnoses/impressions include cervical spine herniated nucleus pulposus; cervical radiculopathy; cervical spine degenerative disc disease; bilateral shoulder pain; thoracic spine pain; lumbago; anxiety disorder; mood disorder; sleep disorder; and stress. Treatment to date has included medications, physical therapy, chiropractic treatment and epidural steroid injections (ESI). Electrodiagnostic testing of the bilateral upper extremities on 6/5/15 was normal. Cervical MRI dated 5/12/14 was positive for mild disc degeneration and C5-6 and C6-7 spinal canal stenosis. According to the progress notes dated 5/18/15, the IW reported burning, radicular neck pain and muscle spasms rated 8/10, with numbness and tingling of the bilateral upper extremities; constant, burning bilateral shoulder pain radiating down the arms to the fingers, rated 5/10, with associated muscle spasms; burning, radicular mid back pain rated 5/10; and burning, radicular low back pain and muscle spasms rated 5/10. She also reported experiencing stress, anxiety, insomnia and depression. Her medications temporarily relieved her symptoms and provided more restful sleep. On examination, all areas of the spine were tender to palpation, with spasms noted in the thoracic and lumbar regions. Ranges of motion were decreased in the cervical and lumbar spine and the bilateral shoulders. Motor strength was 4/5 in the lower extremities; reflexes and pulses were 2+ and symmetrical. Sensation was decreased in the L4, L5 and S1 dermatomes bilaterally. A request was made for oral suspensions: Synapryn 10mg/ml, 500ml; Tabradol 1mg/ml, 250ml; Deprizine 15mg/ml, 250ml; Dicopanor 5mg/ml, 150ml; and Fanatrex 25mg/ml, 420ml.

IMR ISSUES, DECISIONS AND RATIONALES

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

Synapryn 10mg/ml oral suspension 500ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 76-96.

Decision rationale: Synapryn is a compounding agent that contains both tramadol, a narcotic, and glucosamine. CA MTUS guidelines require that criteria for continued long-term use of opioids require ongoing review and documentation of pain relief, functional status improvement, appropriate use, screening of side effects and risk for abuse, diversion and dependence. From my review of the provided medical records there is lacking a description of quantifiable improvement with ongoing long-term use of short acting opioids such as the prescribed medication. VAS score has stayed unchanged with no noted improvement in objective physical exam findings or functional capacity. Consequently continued use of short acting opioids is not supported by the medical records and guidelines as being medically necessary. Additionally the need for a compounded agent versus taking generic oral tramadol is not described. The request is not medically necessary.

Tabradol 1mg/ml oral suspension 250ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics Page(s): 64-66.

Decision rationale: Tabradol is a compounded cyclobenzaprine. According to MTUS guidelines, anti-spasmodic agents such as the prescribed medication are "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement." Muscle relaxants are recommended as second line option for short-term treatment of acute exacerbation of muscle spasm in patients with chronic lower back pain. According to the cited guidelines, muscle relaxants provide no additional benefit in managing chronic back pain and spasm beyond NSAIDs, which the patient is already taking regularly. Additionally efficacy appears to diminish over time and prolonged use increases risk of dependence and tolerance. Additionally the need for a compounded agent versus taking generic oral cyclobenzaprine is not described. Consequently, the provided medical records and cited guidelines do not support continued long-

term chronic use of muscle relaxants as being clinically necessary at this time. The request 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 GI symptoms Page(s): 68.

Decision rationale: Deprizine is a compounded agent containing ranitidine. According to the medical records reviewed and the cited guidelines, the above medication is not clinically necessary for the following reasons: there is no evidence of medication related gastritis documented in the clinic record and the patient is not at increased risk of gastritis as risk factors including advanced age, history of peptic ulcer, gastrointestinal bleeding or concurrent use of NSAID with steroids or anticoagulants are lacking. CA MTUS guidelines state that the use of a proton pump inhibitor should be limited to the recognized indications and not prescribed for prophylactic use if there are no risk factors documented. Additionally it is recommend that it be used at the lowest dose for the shortest possible amount of time Considering lack of documented necessity, the medication does not appear to be clinically necessary at this time. Additionally the need for a compounded agent versus taking generic oral ranitidine is not described. The request it not medically necessary.

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, Pain Chapter, Insomnia Treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Compounding agents Page(s): 14.

Decision rationale: Dicopanol is an oral compounding agent of diphenhydramine hydrochloride, an anti-histamine medication used to treat allergic reactions. There is no documented evidence describing the clinical reasoning and necessity of prescribing diphenhydramine hydrochloride. Additionally clinic evidence describing necessity to prescribe a compounding agent and not an oral generic tablet has not been described in the provided clinical record. The request is not medically necessary.

Fanatrex 25mg/ml oral suspension, 420ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 16-17.

Decision rationale: According to CA MTUS "Gabapentin (Neurontin, Gabarone, generic available) has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. (Backonja, 2002) (ICSI, 2007) (Knotkova, 2007) (Eisenberg, 2007) (Attal, 2006) This RCT concluded that gabapentin monotherapy appears to be efficacious for the treatment of pain and sleep interference associated with diabetic peripheral neuropathy and exhibits positive effects on mood and quality of life. Recommended for neuropathic pain (pain due to nerve damage). (Gilron, 2006) (Wolfe, 2004) (Washington, 2005) (ICSI, 2005) (Wiffen-Cochrane, 2005) (Attal, 2006) (Wiffen-Cochrane, 2007) (Gilron, 2007) (ICSI, 2007) (Finnerup, 2007)" While generic oral gabapentin appears to be appropriate treatment for the IW's chronic radicular pain, there is no indication why a compounded agent is needed in lieu of a generic oral agent. Based on the cited guidelines and reviewed records, continued use of fanatrex oral compounding solution is not medically necessary.