

Case Number:	CM15-0160015		
Date Assigned:	08/26/2015	Date of Injury:	01/01/2015
Decision Date:	09/28/2015	UR Denial Date:	07/22/2015
Priority:	Standard	Application Received:	08/17/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

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 is a 39-year-old female who sustained an industrial injury on 01-01-2015 due to a motor vehicle accident. Diagnoses include cervical, thoracic and lumbar spine sprain-strain, herniated nucleus pulposus; thoracic spine pain; low back pain; radiculitis, lower extremity; and sleep disorder. Treatment to date has included medications, extracorporeal shockwave therapy, chiropractic therapy, acupuncture and LINT (Localized Intense Neurostimulation Therapy). According to the progress notes dated 6-17-2015, the IW (injured worker) reported burning, radicular pain and muscle spasms in the neck, mid back and low back, described as constant and moderate to severe. The pain was associated with numbness and tingling of the bilateral upper and lower extremities. She rated her pain 6 to 7 out of 10 and reported it interfered with sleep. She stated her medications provided temporary relief of pain and improved her ability to sleep. Activity restrictions were also helpful reducing her pain. On examination, range of motion (ROM) was decreased in the cervical, thoracic and lumbar spine. The cervical musculature was tender to palpation. Sensation was slightly diminished over the C5 through T1 dermatomes and motor strength was 4 out of 5 in all represented muscle groups in the upper extremities. There was tenderness with spasms over the thoracic paraspinal muscles bilaterally. Heel walking was painful. The lumbar spinal segments at L4-S1 were tender, greater on the left, as were the bilateral posterior superior iliac spines and sciatic notches. Sensation was slightly decreased in the L4 through S1 dermatomes and muscle strength was 4 out of 5 in all the represented muscle groups of the lower extremities. A request was made for Synapryn (10mg-1ml oral suspension

500ml) for treatment of pain without the effects of opioid analgesics and tricyclic antidepressants.

IMR ISSUES, DECISIONS AND RATIONALES

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

Synapryn 10 mg/ 1 ml oral suspension, 500 ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram); Glucosamine (Chondroitine Sulfate).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids
Page(s): 76-84.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to nonopioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids: (a) If the patient has returned to work; (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use of this medication class is not recommended per the California MTUS unless there documented

evidence of benefit with measurable outcome measures and improvement in function. There is no documented significant decrease in objective pain measures such as VAS scores for significant periods of time. There are no objective measures of improvement of function. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.