

Case Number:	CM15-0161724		
Date Assigned:	08/27/2015	Date of Injury:	08/27/2009
Decision Date:	10/09/2015	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: Arizona, Michigan

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 is a 62 year old male, who sustained an industrial injury on August 27, 2009. He reported neck pain, upper extremity pain, mid and low back pain and lower extremity pain secondary to pulling weeds. The injured worker was diagnosed as having cervicalgia, rule out cervical disc displacement, (HNP), rule out cervical spine radiculopathy, lumbar disc displacement (HNP), lumbar spine degenerative disc disease and lumbar radiculopathy. Treatment to date has included diagnostic studies, conservative care, physical therapy, chiropractic care, acupuncture, shockwave therapy, medications and work restrictions. Currently, the injured worker continues to report neck pain, upper extremity pain, mid and low back pain and lower extremity pain. The injured worker reported an industrial injury in 2009, resulting in the above noted pain. He was treated conservatively without complete resolution of the pain. Evaluation on March 26, 2015, revealed continued pain as noted. He rated his pain at 5-6 on a 1-10 scale with 10 being the worst. It was noted he gained temporary relief with the prescribed medications. He denied any bowel or bladder problems. There was positive triggering noted at quadratus lumborum. Medications, physical therapy, acupuncture and chiropractic care were continued. Evaluation on April 30, 2015, revealed continued pain as noted. He rated his neck pain at 4-5 on a 1-10 scale with 10 being the worst and his back pain at 5-6 on a 1-10 scale with 10 being the worst. It was noted the Tripod test, Flip-test and Lasegue's differential were positive. Medications including Deprizine, Dicopanol, Fanatrex, Synaprysn and Tabradol were continued. Evaluation on June 4, 2015, revealed continued pain as noted. He rated his pain at 4-5 on a 1-10 scale with 10 being the worst. It was noted the medications help produce a more

restful sleep however there was no indication of how many hours of sleep he was getting a night currently or prior to taking the medication. He denied any side effects to the medications. Deprizine, Dicopanol, Fanatrex, Synaprysn and Tabradol were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Synapryn 5ml TID/500ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: According to the California (CA) MTUS Guidelines Synapryn is an oral suspension form of an opioid analgesic. Opioid analgesics are recommended after a trial of a first-line therapy has failed. Guidelines offer very specific requirements for the ongoing use of opiate pain medication to treat chronic pain. Recommendations state the lowest possible dose be used as well as "ongoing review and documentation of pain relief, functional status, appropriate medication use and its side effects." It also recommends that providers of opiate medication document the injured worker's response to pain medication including the duration of symptomatic relief, functional improvements, and the level of pain relief with the medications. It was indicated in the documentation use of the prescribed opioid medication did not decrease the level of pain the injured worker reported from one visit to the next. In addition, there was no noted functional improvement or improved pain noted during the duration of the prescription for Synapryn. Furthermore, there was insufficient evidence to support the necessity of prescribing the medication in an oral suspension form versus the FDA approved oral pill form. For these reasons, the request for Synapryn 5ml TID/500ml is not medically necessary.

Tabradol 5ml/250ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Muscle Relaxant).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 63-66.

Decision rationale: According to California (CA) MTUS Guidelines Cyclobenzaprine is a second line treatment secondary to high risk of adverse events. Cyclobenzaprine is recommended for short-term use and to treat acute exacerbations or flare-ups. It was reported the injured worker had been using this medication for months with no noted improvement in functionality or the ability to perform activities of daily living and no noted decrease in pain frequency or intensity. In addition, there is no insufficient evidence to support the necessity of prescribing the medication in an oral suspension form versus the FDA approved oral pill form. Furthermore, there was no indication of the amount prescribed in the requested treatment. For these reasons, the request for Tabradol 5ml/250ml is not medically necessary.

Deprizine 10ml/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 NSAIDS, GI symptoms and cardiovascular risk Page(s): 68-69.

Decision rationale: According to the California (CA) MTUS Guidelines, Deprizine is a histamine-2 blocker recommended for the treatment of gastrointestinal events in individuals with no cardiovascular disease. It is intended to protect the gastrointestinal tract with the concurrent use of NSAIDS. In this case, there is no indication of gastrointestinal problems. There was no diagnosis of dyspepsia secondary to NSAID use and in addition, there was no indication of failed first line therapies with proton pump inhibitors. Furthermore, there was insufficient documentation to support the necessity of using the medication in an oral suspension form versus the FDA approved oral pill form and there was no amount of medication identified in the requested treatment. The request for Deprizine 10ml/250ml is not medically necessary.

Dicopanol 1ml/150ml: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental illness, stress and insomnia treatment.

Decision rationale: The California (CA) MTUS Guidelines are silent on the issue. According to the Official Disability Guidelines (ODG), Dicofanol (Benadryl) is a first generation anti-histamine. The ODG indicates Benadryl is used to treat anxiety disorders and allergic conditions, especially those involving the skin, and as a sleep aid. It was noted tolerance seems to develop within a few day of use when the drug is used as a sleep aid. For chronic insomnia, a combination of a sleep aid and behavioral therapy is recommended with discontinuation of the sleep aid within a short period and if needed continuation of the behavioral therapy after the medication has been discontinued. There was no indication of improved sleep with use of the medication. In addition, there was no indication of intentions of discontinuing the medication after a short period of time. Furthermore, there was insufficient evidence to support the necessity of prescribing the drug in an oral suspension form versus the FDA approved oral pill form. For these reasons, the request for Dicopanol 1ml/150ml is not medically necessary.

Fanatrex 5ml/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 Gabapentin Page(s): 16.

Decision rationale: According to the California (CA) MTUS Guidelines, Gabapentin (Fanatrex) is shown to be effective for the treatment of diabetic neuropathy and post-herpetic neuralgia and has been considered a first line treatment for neuropathic pain. The documentation provided did not include evidence of improved function or documentation of efficacy of the medication. Ongoing assessments of pain and function supported with tools of measurement were provided but did not indicate significant improvement. Additionally, there was insufficient evidence to indicate the necessity for the drug to be prescribed in an oral suspension form versus the FDA approved oral pill form. For these reasons, the request for Fanatrex 5ml/420ml is not medically necessary.