

<b>Case Number:</b>	CM15-0042998		
<b>Date Assigned:</b>	03/16/2015	<b>Date of Injury:</b>	02/10/2010
<b>Decision Date:</b>	05/22/2015	<b>UR Denial Date:</b>	02/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/06/2015

### 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

Certification(s)/Specialty: Pediatrics, Internal 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 56-year-old male, who sustained an industrial injury on February 10, 2010. The injured worker was diagnosed as having cervical spine sprain/strain, cervical spine radiculopathy, right shoulder pain, left shoulder rotator cuff tear, bilateral wrist internal derangement, lumbar spine HNP, lumbar spine radiculopathy, bilateral knee pain, chondromalacia of the right knee, bilateral ankle pain, bilateral ankle tenosynovitis, and plantar fasciitis of the left foot. Treatment to date has included medications, physical therapy for the bilateral shoulder and knees, MRI of the left/right ankle, left/right wrist, left/right shoulder, extracorporeal shockwave therapy, and acupuncture, injections. Currently, the injured worker complains of burning, radicular neck pain and muscle spasms and notes that the pain radiates to the bilateral upper extremities associated with numbness and tingling. The injured worker has burning bilateral shoulder pain, which radiates into the arms to the fingers and associated muscle spasms. He reports burning bilateral wrist pain and muscles spasms, burning bilateral knee pain, and aching bilateral ankle pain. He has burning radicular low back pain with muscle spasms. The injured worker reports that his medications offer temporary pain relief and improve his ability to have a restful sleep. On examination, he has tenderness to palpation to the cervical spine, the bilateral shoulders, bilateral wrists and hands, lumbar spine and bilateral ankle/feet. The treatment plan includes Terocin patches for pain relief, orthopedic surgeon consultation, and physical therapy for the bilateral shoulder, knees, cervical and lumbar spine and acupuncture of the cervical and lumbar spine, bilateral shoulders and knees. Deprizine, Dicopanil, Fanatrex, Synapryn and Tabradol were recommended for pain.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Dipriline 15mg/ml oral suspension 250ml: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Compound drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

**Decision rationale:** The indication for proton pump inhibitor use is intermediate or high risk of GI side effects. The risk factors include age > 65 years, history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant and or high dose/multiple NSAID. There was no notation of GI symptoms or a history of risk factors. This request is not medically necessary or appropriate.

### **Dicopanol (diphenhydramine) 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 (ODG), Mental Illness & Stress Chapter, Insomnia treatment; Pharmacologic treatment; Non-pharmacologic treatment; Compound drugs; Criteria for Compound drugs.

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

**Decision rationale:** Per ODG pharmacological agents for insomnia should only be used after careful evaluation of potential causes of sleep disturbance for the etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. There is no discussion of an investigation into the origin of the sleep disturbance and non-pharmacological interventions that may have been utilized. Sedating antihistamines have been suggested for sleep aids, tolerance seems to develop within a few days. Prolonged use is not recommended. There was no documentation of objective functional benefit with prior use of these medications. This request is not medically necessary and appropriate.

### **Synapryn 10ml/1ml oral suspension 500ml: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Clucosamine (and Chondroitin Sulfate). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Compound drugs; Criteria for compound drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use 4) On-Going Management Page(s): 78.

**Decision rationale:** The IW is documented to be on an opioid for pain relief. Documentation did not include 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. This request is not medically necessary and reasonable.

**Fanax (gabapentin) 25mg/ml oral suspension 420ml:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin, Gabarone, generic available). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chapter, Gabapentin (Neurontin); Compound drugs; Criteria for Compound drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 15-19.

**Decision rationale:** MTUS guidelines state that antiepileptic drugs are recommended for neuropathic pain. A "good" response to the use of AEDs has been defined as a 50% reduction in pain and a 'moderate' response as a 30% reduction. Neurontin has been considered as a first-line treatment for neuropathic pain. The patient should be asked at each visit as to whether there has been a change in pain or function. It is noted that there is no EMG/NCV to document neuropathy in the IW. As the medication was ineffective and was, being weaned off this request is not medically necessary and reasonable.

**Tabradol 1mg/ml oral suspension 240ml:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain); Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Compound drugs; Criteria for Compound drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-64.

**Decision rationale:** Muscle relaxants are recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. The greatest effect appears to be in the first 4 days of treatment. The documentation does not reference any muscle spasm that the Flexeril would be used for and at this time frame it is not indicated. This request is not medically necessary and appropriate.