

Case Number:	CM15-0047249		
Date Assigned:	03/19/2015	Date of Injury:	05/04/2011
Decision Date:	04/24/2015	UR Denial Date:	02/17/2015
Priority:	Standard	Application Received:	03/12/2015

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: Texas, Florida, California
 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 29 year old male who sustained a work related injury May 4, 2011. While working with a cement hose pump, it malfunctioned and struck him in the head. He felt a pop and stiffness in the low back and fell to the ground and noted pain in his neck. He was initially seen for chiropractic evaluation and treatment, x-rays, and physiotherapy modalities for four months with temporary relief. According to a secondary physician's pain management initial report dated December 23, 2014, the injured worker was examined and impression is documented as multiple level lumbar disc protrusion and lumbar radiculopathy. There is chronic severe neck pain present. He has spasms that radiates to the left leg with numbness, tingling and weakness and uses a cane for ambulation. Recommendation included epidural steroid injection L4-5. A secondary treating physician's progress report dated January 5, 2015, finds the injured worker presenting with low back pain (80%) and left greater than right leg pain (20%). Diagnosis is documented as lumbosacral disc protrusion. Treatment included requests for MRI, electromyography studies bilateral lower extremities, and qualified medical examination, and request for authorization for continued medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Request Syrapyn (DOS 1/09/2015): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : Pain interventions and treatments 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 12,13 83 and 113 of 127.

Decision rationale: Synapryn is tramadol hydrochloride 10 mg/mL, in oral suspension with glucosamine - compounding kit). The most pharmacologically active component is the Tramadol. Per the MTUS, Tramadol is an opiate analogue medication, not recommended as a first-line therapy. The MTUS based on Cochrane studies found very small pain improvements, and adverse events caused participants to discontinue the medicine. Most important, there are no long term studies to allow it to be recommended for use past six months. A long term use of is therefore not supported, and the request is retrospectively non-certified and not medically necessary.

Retro Request Tabradol (DOS 1/09/2015): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 41-42 of 127.

Decision rationale: Tabradol is a formulation of cyclobenzaprine. The MTUS recommends cyclobenzaprine for a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. The addition of cyclobenzaprine to other agents is not recommended. In this case, there has been no objective functional improvement noted in the long-term use of Flexeril in this claimant. Long term use is not supported. Also, it is being used with other agents, which also is not clinically supported in the MTUS and is retrospectively non-certified and not medically necessary.

Retro Request Deprizine (DOS 1/09/2015): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, under Antidepressants.

Decision rationale: Deprazine is an antidepressant. The MTUS is silent on this medicine. Regarding antidepressants to treat a major depressive disorder, the ODG notes: Recommended for initial treatment of presentations of Major Depressive Disorder (MDD) that are moderate, severe, or psychotic, unless electroconvulsive therapy is part of the treatment plan. Not

recommended for mild symptoms. In this case, it is not clear what objective benefit has been achieved out of the antidepressant usage, how the activities of daily living have improved, and what other benefits have been. It is not clear if this claimant has a major depressive disorder. The request is appropriately retrospectively non-certified and not medically necessary.

Retro Request Dicopanol (DOS 1/09/2015): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Physician Desk References, 2014 web edition, under Dicopanol.

Decision rationale: Dicopanol is a suspension including diphenhydramine. Per the Physician Desk Reference, this is a medicine used for allergy. The records do not portray the patient as having an allergic condition. The use of the medicine to aid the injury care is not clinically clear based on the records. Further, it is not clear why a suspension formulation is needed vs ordinary tablets. The request is appropriately retrospectively not clinically certified and not medically necessary.

Retro Request Fanatrex (DOS 1/09/2015): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 16 of 127 and page 19 of 127.

Decision rationale: Fanatrex is an oral suspension of gabapentin. The MTUS notes that anti-epilepsy drugs (AEDs) like Gabapentin are also referred to as anti-convulsants, and are recommended for neuropathic pain (pain due to nerve damage). However, there is a lack of expert consensus on the treatment of neuropathic pain in general due to heterogeneous etiologies, symptoms, physical signs and mechanisms. It is not clear in this case what the neuropathic pain generator is, and why therefore that Gabapentin is essential. 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. This claimant however has neither of those conditions. Also, it is not clear why an oral suspension is needed over plain tablets. The request is appropriately retrospectively non-certified under the MTUS evidence-based criteria and is not medically necessary.