

Case Number:	CM15-0086137		
Date Assigned:	05/08/2015	Date of Injury:	06/03/2014
Decision Date:	09/10/2015	UR Denial Date:	04/21/2015
Priority:	Standard	Application Received:	05/05/2015

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

Certification(s)/Specialty: Emergency 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 48 year old female who sustained an industrial injury on 06/03/2014. She reported a twist to the left and a popping sound in the right knee on 06/03/2014 followed by knee surgery for torn cartilage in her knee. Post-surgery she also had pain in the back and left shoulder. The injured worker was diagnosed as having cervical spine sprain/strain, rule out herniated nucleus pulposus; cervical radiculopathy; lumbar spine sprain/strain, rule out herniated nucleus pulposus; lumbago; lumbar radiculopathy; left knee sprain/strain rule out internal derangement; status post left knee surgery; left ankle/foot sprain/strain rule out internal derangement, and hypertension. Treatment to date has included surgery, MRI, and medications. Currently, the injured worker complains of neck pain rated at a 6- 7/10 that is burning, radicular neck pain and muscle spasms. The pain is described as constant, moderate to severe and radiates to the bilateral upper extremities. It is aggravated by head motion. Low back pain is rated a 7- 8/10, with burning radicular low back pain tingling and numbness to bilateral lower extremities. The pain is aggravated by prolonged positioning, arising from a sitting position, sitting, standing, walking, and bending. The pain is also present when ascending or descending stairs. She has left knee/ankle/foot pain rated a 7-8/10. This is aggravated by squatting, kneeling, ascending or descending stairs, and prolonged positioning, weight bearing, standing and walking. She has numbness, tingling and pain radiating to the foot. On examination there is decreased range of motion in all planes of the cervical spine with tenderness to palpation at the sub occipital region and both scalene and trapezius muscles. Cervical distraction and cervical compression are both positive in both the left and right. Examination of the bilateral upper extremities show decreased motor strength with deep tendon reflexes 2+ and symmetrical.

Sensation to pinprick and light touch is diminished over C5 through T1 dermatomes. Examination of the lumbar spine demonstrates decreased range of motion and palpable tenderness with spasms in the lumbar paraspinal muscles and over the lumbosacral junction. The left knee has a well healed surgical scar consistent with prior surgery, and there is tenderness to palpation over the medial and lateral joint line. There is no instability of the knee, but there is decreased range of motion. The treatment plan includes topical medications and referrals to the appropriate specialists. A request for authorization is made for: 1. Synapryn 10 mg/1 ml Oral Suspension 500 ml, 2. Tabradol 1 mg/ml Oral Suspension 250 ml, 3. Deprizine 15 mg/ml Oral Suspension 250 ml, 4. Dicopanor (Diphenhydramine) 5 mg/ml Oral Suspension 150 ml, and 5. Fanatr.

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: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain chapter - Compound medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80-83 of 127.

Decision rationale: The request is for the use of a medication in the category of an anti-epileptic drug (AED). These medications are recommended for certain types of neuropathic pain. Most of the randomized clinical control trials involved include post-herpetic neuralgia and painful polyneuropathy such as in diabetes. There are few trials which have studied central pain or radiculopathy. The MTUS guidelines state that a good response to treatment is 50% reduction in pain. At least a 30% reduction in pain is required for ongoing use, and if this is not seen, this should trigger a change in therapy. There also should be documentation of functional improvement and side effects incurred with use. Disease states which prompt use of these medications include post-herpetic neuralgia, spinal cord injury, chronic regional pain syndrome, lumbar spinal stenosis, post-operative pain, and central pain. There is inadequate evidence to support use in non-specific axial low back pain or myofascial pain. In this case, there is inadequate documentation of a condition which would support the use of an anti-epileptic drug. The records also do not reveal functional improvement or screening measures as required. As such, the request is not medically necessary.

Tabradol 1 mg/ml Oral Suspension 250 ml: 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 - Compound medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63 of 127.

Decision rationale: The request is for the use of a muscle relaxant to aid in pain relief. The MTUS guidelines state that the use of a medication in this class is indicated as a second-line option for short-term treatment of acute exacerbations of low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, which can increase mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain improvement. Efficacy appears to diminish over time, and prolonged use may lead to dependence. (Homik, 2004) Due to inadequate qualifying evidence for use of a muscle relaxant, the request is not medically necessary.

Deprizine 15 mg/ml Oral Suspension 250 ml: 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 - Compound medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68 of 127.

Decision rationale: The request is for the use of a medication in the class of an acid reducing medication. The guidelines do not specifically address or advise the use of an H2 blocker but does make recommendations regarding medications in the same category classified as proton pump inhibitors. This is usually given for patients with esophageal reflux, gastritis, or peptic ulcer disease. It can also be used as a preventative measure in patients taking non-steroidal anti-inflammatories for chronic pain which have side effects including gastrointestinal disease. The MTUS guidelines states that patients who are classified as intermediate or high risk, should be treated prophylactically with a proton pump inhibitor or Misoprostol. Criteria for risk are as follows: "(1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)." Due to the fact the patient does not meet to above stated criteria, the request for use is not medically necessary.

Dicopanol (Diphenhydramine) 5 mg/ml Oral Suspension 150 ml: 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 - Compound medications.

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 and Stress, Diphenhydramine (Benadryl).

Decision rationale: The request is for the use of Diphenhydramine which is in the category of an antihistamine. The MTUS guidelines are silent regarding this topic. The ODG states the following regarding its use: Not recommended. See Insomnia treatment, where sedating antihistamines are not recommended for long-term insomnia treatment. The AGS updated Beers criteria for inappropriate medication use includes diphenhydramine. (AGS, 2012)

Anti-cholinergic drugs, including diphenhydramine, may increase the risk for dementia by 50% in older adults. There is an obvious dose-response relationship between anti-cholinergic drug use and risk of developing dementia, but chronic use, even at low doses, would be in the highest risk category. While there is awareness that these drugs may cause short-term drowsiness or confusion, which is included in the prescribing information, there is no mention of long-term effects on cognition, and generally awareness of this issue is very low, and both the public and doctors need to be encouraged to use alternative treatments where possible. (Gray, 2015) As stated above, the use of this medication is not indicated for use in this patient for insomnia. There is inadequate documentation of the reasoning for its use for other indications. As such, the request is not medically necessary.

Fanatr: 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 - Compound medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-17 of 127.

Decision rationale: The request is for the use of a medication in the category of an anti-epileptic drug (AED). These medications are recommended for certain types of neuropathic pain. Most of the randomized clinical control trials involved include post-herpetic neuralgia and painful polyneuropathy such as in diabetes. There are few trials which have studied central pain or radiculopathy. The MTUS guidelines state that a good response to treatment is 50% reduction in pain. At least a 30% reduction in pain is required for ongoing use, and if this is not seen, this should trigger a change in therapy. There also should be documentation of functional improvement and side effects incurred with use. Disease states which prompt use of these medications include post-herpetic neuralgia, spinal cord injury, chronic regional pain syndrome, lumbar spinal stenosis, post-operative pain, and central pain. There is inadequate evidence to support use in non-specific axial low back pain or myofascial pain. In this case, there is inadequate documentation of a condition which would support the use of an anti-epileptic drug. The records also do not reveal functional improvement or screening measures as required. As such, the request is not medically necessary.