

<b>Case Number:</b>	CM14-0213327		
<b>Date Assigned:</b>	12/30/2014	<b>Date of Injury:</b>	02/16/2012
<b>Decision Date:</b>	02/27/2015	<b>UR Denial Date:</b>	12/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/19/2014

### 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, Texas  
 Certification(s)/Specialty: 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 61year old man with a work related injury dated 2/16/12 resulting in chronic pain of the left upper extremity. The patient was evaluated by the primary treating physician on 11/5/14. The patient continued to complain of shoulder pain, radicular neck pain and mid back pain. The physical exam showed left shoulder tenderness to palpation at the joint, subacromial space, and musculature. The range of motion was decreased. The plan of care included physical therapy to the cervical spine and upper extremity and multiple oral analgesic medications in the form of oral suspensions. The diagnosis included cervical spine sprain/strain, cervical radiculopathy, cervical spine pain, left shoulder sprain/strain, left wrist enosynovitis and thoracic and lumbar sprain/strain. There was no documentation that the patient was unable to take medications in the pill/tablet form. Under consideration is physical therapy for the left shoulder 3x a week for 6 weeks and the oral medications including Synapryn, Tabradol, Deprizine, Dicopanol and Fanatrex which were all denied as not medically necessary during utilization review dated 12/2/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-.26 Page(s): 98-99.

**Decision rationale:** Passive therapy can provide short-term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. Physical Medicine Guidelines state that it should be allowed for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. In this case the patient is being treated for chronic pain. There is no documentation of acute injury or recent surgery. The amount of physical therapy of 3 sessions/week for 6 weeks is excessive and not medically necessary.

**Synapryn 10mg/ml 500ml:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-.26 Page(s): 74-96. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Uptodate.com. Drug information. Drugs.com

**Decision rationale:** Synapryn is a compounded medication containing tramadol hydrochloride 10mg/ml and glucosamine in oral suspension. Tramadol is a synthetic opioid affecting the central nervous system. Its use may increase the risk of seizure especially in patients taking SSRIs, TCAs and other opioids. Tramadol may produce life-threatening serotonin syndrome, in particular when used concomitantly with SSRIs, SNRIs, TCAs and MAOIs, and triptans or other drugs that may impair serotonin metabolism. Tramadol is indicated for moderate to severe pain. With regards to using opioids for chronic pain they have been suggested for neuropathic pain that has not responded to first-line recommendations (antidepressants, anticonvulsants). There are not trials of long-term use. The use of opioids for chronic back pain appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16weeks), but also appears limited. The major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (<70 days). This leads to a concern about confounding issues such as tolerance, opioid-induced hyperalgesia, long-range adverse effects such as hypogonadism and/or opioid abuse. The major goal of continued use is improved functional status. In this case the documentation doesn't support failure of a first line medication for neuropathic pain or functional improvement due to tramadol. Furthermore, the documentation doesn't support the need for a compounded oral suspension. The use of Synapryn is not medically necessary.

**Tabradol 1mg/ml 250 ml: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-.26 Page(s): 64-66.

**Decision rationale:** Tabradol is a compounded oral suspension containing cyclobenzaprine hydrochloride 1mg/ml. According to the MTUS section on chronic pain muscle relaxants (such as cyclobenzaprine) are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain (LBP). Muscle relaxants may be effective in reducing pain and muscle tension and increasing mobility. In most cases of LBP they show no benefit beyond NSAIDS in pain and overall improvement and offer multiple side effects including sedation and somnolence. In this case there is not documentation that the patient has failed treatment with a first line drug or that they require an oral suspension for treatment. The continued use of Tabradol is not medically necessary.

**Deprizine 15mg/ml 250ml: 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 Other Medical Treatment Guideline or Medical Evidence: Uptodate.com. Ranitidine drug information. Drugs.com

**Decision rationale:** Deprizine contains ranitidine hydrochloride 16.8 mg/ml, in oral suspension-compounding kit. The documentation notes abdominal pain with discomfort without any diagnosis of GERD or peptic ulcer disease. FDA approved uses for ranitidine include duodenal ulcers, eradication of H. Pylori, GERD, stress ulcer prophylaxis and heartburn. The documentation doesn't support that the patient has any of these diagnosis or that the patient is unable to take a tablet thus requiring an oral suspension. The continued use of Deprizine is not medically necessary.

**Dicopanor 5mg/ml 150ml: 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 Other Medical Treatment Guideline or Medical Evidence: Uptodate.com. Drug information. Drugs.com

**Decision rationale:** Dicopanor contains diphenhydramine hydrochloride 5mg/ml in oral suspension kit. FDA approved uses for diphenhydramine include allergic reactions, antitussive,

motion sickness, insomnia (occasional), parkinsonism and rhinitis. In this case the patient does not have a diagnosis of insomnia. The documentation supports that the patient has a diagnosis of chronic pain. There is no documentation to support that the patient requires oral suspension. The continued use of Decopenol is not medically necessary.

**Fanatrex 25mg/ml 420ml:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-.26 Page(s): 49.

**Decision rationale:** According to the MTUS gabapentin is an anti-epilepsy drug (AED), which 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. In this case the documentation doesn't support that the patient has a diagnosis of diabetic neuropathy and postherpetic neuralgia. The use is for neuropathic pain however there is no documentation that a compounded oral suspension (Fanatrex 25mg/ml) is medically necessary due to difficulty taking pills/tablets. The continued use of Fanatrex is not medically necessary.