

Case Number:	CM15-0111101		
Date Assigned:	06/17/2015	Date of Injury:	10/29/2014
Decision Date:	09/16/2015	UR Denial Date:	06/05/2015
Priority:	Standard	Application Received:	06/09/2015

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: Maryland

Certification(s)/Specialty: Internal Medicine, Rheumatology

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 22 year old male who reported an industrial injury on 10/29/2014. His diagnoses, and/or impressions, are noted to include: lumbar disc displacement with herniated nucleus pulposus and low back pain; lower extremity radiculitis; and thoracic spine sprain/strain with pain. No current imaging studies are noted. His treatments have included diagnostic studies; medication management and rest from work. The progress notes of 1/6/2015 noted a follow-up visit with complaints of constant, mild-moderate mid back pain that is aggravated by activities and improved by activity restrictions and medications; constant, burning, mild-moderate, radicular low back pain, associated with numbness/tingling in the bilateral lower extremities, aggravated by activities and activities of daily living, and improved by activity restrictions and medications; and that medications offer him temporary relief from his pain and improvement in his ability to sleep. Objective findings were noted to include no acute distress; tenderness at the rhomboids, trapezius muscles and over the thoracic spinous process; tenderness, without spasms, over the lumbar para-spinal muscles, quadratus lumborum muscles, and lumbosacral junction with decreased range-of-motion and positive Tripod sign and flip test; a slight decrease in sensation of the lumbosacral dermatomes bilaterally; and decreased strength in the lower extremities. The physician's requests for treatments were noted to include the continuation of Synapryn, Tabradol, Deprizine; Dicopanol, and Fanatrex.

IMR ISSUES, DECISIONS AND RATIONALES

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

Date of prescription (03/10/2015) Synapryn 10mg /1ml oral suspension 500ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 93-94, 78-80, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-85, 88-89.

Decision rationale: This 22 year old male has complained of low back pain since date of injury 10/29/14. He has been treated with physical therapy and medications. The current request is for Synapryn 10mg/1ml. No treating physician reports adequately assess the patient with respect to function, specific benefit, return to work, signs of abuse or treatment alternatives other than opioids. There is no evidence that the treating physician is prescribing opioids according to the MTUS section cited above which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, opioid contract and documentation of failure of prior non-opioid therapy. On the basis of this lack of documentation and failure to adhere to the MTUS guidelines, Synapryn is not medically necessary.

(Date of prescription 03/10/2015) Tabradol 1mg/1ml oral suspension 250ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63-64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

Decision rationale: This 22 year old male has complained of low back pain since date of injury 10/29/14. He has been treated with physical therapy and medications. The current request is for Tabradol 1mg/1ml. Per MTUS guidelines, treatment with cyclobenzaprine should be reserved as a second line agent only and should be used for a short course (2 weeks) only; additionally, the addition of cyclobenzaprine to other agents is not recommended. Per MTUS guidelines, cyclobenzaprine is not medically necessary for this patient.

(Date of prescription 03/10/2015) Deprizine 15mg/ml oral suspension 250ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines non-steroidal anti-inflammatory drugs (NSAIDs) Page(s): 68-69.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.drugs.com/zantac.

Decision rationale: This 22 year old male has complained of low back pain since date of injury 10/29/14. He has been treated with physical therapy and medications. The current request is for Deprizine 15 mg/ml. Zantac is a medication used to treat symptoms of heartburn and

gastroesophageal reflux related disease. There is no documentation in the available medical records of medical rationale regarding the necessity use of this medication. On the basis of the above cited medical treatment guideline and the available provider documentation, Deprizine is not medically necessary in this patient.

(Date of prescription 03/10/2015) Dicopanor (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, Pain.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.drugs.com/benadryl.

Decision rationale: This 22 year old male has complained of low back pain since date of injury 10/29/14. He has been treated with physical therapy and medications. The current request is for Dicopanor. Dicopanor is an antihistamine suspension (diphenhydramine) used to treat allergic rhinitis and motion sickness and may also be used to induce sleep. There is no specific indication or recommendation per evidenced based guidelines for use of this medication in chronic musculoskeletal pain. There are no diagnoses listed in the available medical records which support the use of this medication and no documentation regarding the specific need for a suspension formulation. On the basis of current evidenced based medical guidelines and the available documentation, Dicopanor is not medically necessary in this patient.

(Date of prescription 03/10/2015) Fanatrex (gabapentin) 25mg/ml oral suspension 420ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anti-epilepsy drugs / anti-convulsants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epileptic drugs Page(s): 49.

Decision rationale: This 22 year old male has complained of low back pain since date of injury 10/29/14. He has been treated with physical therapy and medications. The current request is for Fanatrex. Per the MTUS guideline cited above, gabapentin is an anti-epileptic agent recommended to treat diabetic painful neuropathy and post herpetic neuropathy. There is no documentation in the available medical records that supports the presence of any of these medical conditions. On the basis of this lack of documentation, Fanatrex is not medically necessary.