MAXIMUS Federal Services

Case Number:	CM15-0177228		
Date Assigned:	09/17/2015	Date of Injury:	07/26/2014
Decision Date:	10/20/2015	UR Denial Date:	09/01/2015
Priority:	Standard	Application Received:	09/09/2015

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: North Carolina
Certification(s)/Specialty: Family Practice

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 48 year old female, who sustained an industrial injury on July 26, 2014. The injured worker was being treated for cervical spine herniated nucleus pulposus, cervical radiculopathy, bilateral shoulders sprain and strain rule out internal derangement, lumbar spine herniated nucleus pulposus, lumbago, and lumbar radiculopathy. Medical records (May 4, 2015 to August 17, 2015) indicate ongoing, constant, burning, radicular neck pain with numbness and tingling of the bilateral upper extremities. The pain is aggravated by repetitive head motion and looking up, down, and side to side. There is ongoing, constant, burning pain of the bilateral shoulders, which is aggravated by gripping, grasping, reaching, pulling, lifting, and working at or above the shoulder level. In addition, there is ongoing, constant, burning, radicular low back pain with numbness and tingling of the bilateral lower extremities. The pain is aggravated by prolonged sitting, standing, walking, bending, arising from sitting, ascending or climbing stairs, and stooping. Dressing and performing personal hygiene aggravate the pain, also. The medical record show no change in the subjective pain rating of neck and low back pain 5-6 of 10 and bilateral shoulder pain of 6 out of 10 on May 4, 2015 to August 17, 2015. The physical exam (May 4, 2015 to August 17, 2015) reveals decreased cervical range of motion and tenderness to palpation at the suboccipital region and the bilateral scalene and trapezius muscles. There is decreased bilateral shoulder range of motion, tenderness at the delto-pectoral groove and the insertion of the bilateral supraspinatus muscles, decreased sensation over the C5 (cervical 5) through T1 (thoracic 1) dermatomes in the bilateral upper extremities, and decreased motor strength due to pain in the bilateral upper extremities. There is ability to heel-toe walk, pain with

toe walking, 50% of normal squat due to low back pain, low back pain with toe touch at 4 inches from the ground, tenderness to palpation with spasms at the lumbar paraspinal muscles and over the lumbosacral junction, and decreased lumbar range of motion. There is decreased sensation at the L4 (lumbar 4) through S1 (sacral 1) dermatomes and decreased motor strength due to pain in the bilateral lower extremities. On April 15, 2015, a MRI of the cervical spine with flexion and extension revealed disc desiccation at C2-C3 (cervical 2-cervical 3) down to C6-C7 (cervical 6-cervical 7) with associated loss of disc height. At C3-4 (cervical 3-4), there is a broad-based disc herniation causing spinal canal stenosis, disc material abutting the anterior aspect of the spinal cord and mild bilateral uncovertebral joint degenerative change. Disc material and uncovertebral joint degenerative change causes left neural foraminal stenosis with deviation of the left C4 exiting nerve roots. At C4-C5 (cervical 4-cervical 5) and C5-C6 (cervical 5-cervical 6), there are broad-based disc herniations causing spinal canal stenosis, disc material deforms the anterior aspect of the spinal cord and mild bilateral uncovertebral joint degenerative change. Disc material and uncovertebral joint degenerative change causes bilateral neural foraminal stenosis with deviation of the left C5 and C6 exiting nerve roots. At C6-C7 (cervical 6-cervical 7), there is a diffuse disc herniation causing spinal canal stenosis and bilateral uncovertebral joint degenerative change. Disc material and uncovertebral joint degenerative change causes left neural foraminal stenosis with deviation of the left C7 exiting nerve roots. On April 15, 2015, a MRI of the lumbar spine revealed straightening of the lumbar lordotic curvature with limited range of motion in the flexion and extension positions. There is grade 1 anterior listhesis of L4 (lumbar 4) on L5 (lumbar 5) in the flexion and extension positions, disc desiccation and decreased disc height anterior L5-S1 (lumbar 5-sacral 1), early desiccation at L4-L5, and ce ntral disc herniations at L4-L5 and L5-S1 indenting the thecal sac. On April 15, 2015, a MRI of the bilateral shoulders revealed osteoarthritis of the acromioclavicular joint, partial thickness tears of the supraspinatus and infraspinatus, synovial effusion, subacromial and subdeltoid bursitis, subcortical cysts in the humeral head, and partial thickness tears of the horizontal biceps tendon and subscapularis. In addition, there is an anterior labrum tear of the right shoulder and a superior labrum tear of the left shoulder. Treatment has included physical therapy, chiropractic therapy, acupuncture, and medications including oral pain (Tabradol since at least December 2014), topical pain, muscle relaxant Cyclobenzaprine and Tabradol since at least December 2014), histamine 2 antagonist (Deprizine since at least December 2014), and non-steroidal anti-inflammatory. Per the treating physician (August 17, 2015 report), the employee has not returned to work. The requested treatments included Synapryn 10mg/1ml oral suspension, Tabradol 1mg/ml oral suspension, and Deprizine 15mg/ml oral suspension. On September 1, 2015, the original utilization review non-certified requests for Synapryn 10mg/1ml oral suspension 500ml with 0 refills, Tabradol 1mg/ml oral suspension 250ml with 0 refills, and Deprizine 15mg/ml oral suspension 250ml.

IMR ISSUES, DECISIONS AND RATIONALES

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

Synapryn 10mg/1ml oral suspension 500ml with 0 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing 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. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain dairy that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to nonopioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids: (a) If the patient has returned to work (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documented significant decrease in objective pain measures such as VAS scores for significant periods of time. There are no objective measures of improvement of function or how the medication improves activities. The work status is not mentioned. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.

Tabradol 1mg/ml oral suspension 250ml with 0 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: The California chronic pain medical treatment guidelines section on muscle relaxants states: Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) (Chou, 2004) This medication is not intended for long-term use per the California MTUS. The medication has not been prescribed for the flare-up of chronic low back pain but rather ongoing back pain This is not an approved use for the medication. For these reasons, criteria for the use of this medication have not been met. Therefore, the request is not medically necessary.

Deprizine 15mg/ml oral suspension 250ml: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Consultation.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation PDR, deprizine.

Decision rationale: The ACOEM and the California MTUS does not address the requested service. The physician desk reference states the requested medication is indicated in the treatment of GERD dyspepsia and peptic ulcer disease. The patient does not have these diagnoses due to industrial incident. Therefore, the request is not medically necessary.