

Case Number:	CM15-0027638		
Date Assigned:	02/20/2015	Date of Injury:	12/06/2011
Decision Date:	07/09/2015	UR Denial Date:	01/19/2015
Priority:	Standard	Application Received:	02/13/2015

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: New York, Tennessee
 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 is a 66 year old male, who sustained an industrial injury on December 6, 2011. The injured worker was diagnosed as having bilateral shoulder rotator cuff tear, low back pain, lumbar intervertebral disc displacement and lumbar degenerative disc disease (DDD). Treatment and diagnostic studies to date have included medication. A progress note dated December 15, 2014 provides the injured worker complains of bilateral shoulder pain radiating down the arms to his fingers. He also has low back pain that radiates to the hips. He rates his pain 8/10 in both area and reports medication and decreased activity helps. Physical exam notes tenderness of shoulders and lumbar spine with decreased range of motion (ROM). The plan includes oral medication, Terocin patches, functional capacity evaluation and lab work.

IMR ISSUES, DECISIONS AND RATIONALES

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

Synapryn (10mg/1ml) 500ml: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Chronic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines page(s): 50, 74-96.

Decision rationale: Synapryn is a compound medication containing tramadol and glucosamine. Tramadol is a synthetic opioid affecting the central nervous system. It has several side effects, which include increasing the risk of seizure in patients taking SSRI's, TCAs and other opioids. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain of function. It is recommended for short-term use if first-line options, such as acetaminophen or NSAIDS have failed. In this case the patient has been receiving Synapryn since at least May 2014 and has not obtained analgesia. In addition there is no documentation that the patient has signed an opioid contract. Criteria for long-term opioid use have not been met. Tramadol is not recommended. Glucosamine is recommended as an option, in patients with moderate arthritis pain, especially for knee osteoarthritis. Multiple controlled clinical trials of glucosamine in osteoarthritis (mainly of the knee) have been completed and controversy on efficacy related to symptomatic improvement continues. Glucosamine may not be helpful for patients with osteoarthritis of the hip or knee, according to the results of a recent meta-analysis in BMJ, but the authors concluded the medication is not dangerous, and there is no harm in having patients continue the medication as long as they perceive a benefit and cover the costs of treatment themselves. Glucosamine is recommended. The guidelines state that "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended". This medication contains a medication that is not recommended. Therefore the medication cannot be recommended. The request is not medically necessary.

Tabradol 1mg/ml 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, Chronic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines page(s): 63.

Decision rationale: Tabradol is the muscle relaxant cyclobenzaprine. Cyclobenzaprine is a muscle relaxant. Cyclobenzaprine is recommended as an option, for a short course of therapy. It has been found to be more effective than placebo with greater adverse side effects. Its greatest effect is in the first 4 days. Treatment should be brief. Non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment (less than two weeks) of acute exacerbations in patients with chronic LBP. 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. Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. In this case the patient has been taking tabradol since at least May 2014. The duration of treatment surpasses the recommended short-term duration of two weeks. The request is not medically necessary.

Deprizine 15mg ml 250ml: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Chronic Pain.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Medical Letter on Drugs and Therapeutics; March 8, 2010 (Issue 1333) p. 17: Primary Prevention of Ulcers in Patients Taking Aspirin or NSAIDs.

Decision rationale: Deprizine is ranitidine, an H2-receptor antagonist. It is indicated for the treatment of peptic ulcer disease and been shown to prevent NSAID-related gastric ulcers in high doses. In this case there is no documentation to support the diagnosis of ulcer disease. The patient did not have any complaint of nausea or dyspepsia. Medical necessity has not been established. The request is not medically necessary.

Dicopanl 5mg/ml 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, Chronic Pain.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Insomnia Treatment.

Decision rationale: Dicopanl is the antihistamine diphenhydramine. In this case it is being used for the treatment of insomnia. Insomnia treatment should be based on etiology. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine). Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. Side effects include urinary retention, blurred vision, orthostatic hypotension, dizziness, palpitations, increased liver enzymes, drowsiness, dizziness, grogginess and tiredness. In this case the patient has been taking dicopanl since at least May 2014. The benefits of diphenhydramine are outweighed by its adverse effects. The request is not medically necessary.

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Chronic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain
Fanatrex 25mg/ml 420ml: Upheld

Interventions and Guidelines Page(s): 18-19.

Decision rationale: Fanatrex is the anti-epileptic medication, gabapentin. Gabapentin 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 and has FDA approval for treatment of post-herpetic neuralgia. Gabapentin appears to be effective in reducing abnormal hypersensitivity, to have anti-anxiety effects, and may be beneficial as a sleep aid. Gabapentin has a favorable side-effect profile, few clinically significant drug-drug interactions and is generally well tolerated; however, common side effects include dizziness, somnolence, confusion, ataxia, peripheral edema, dry mouth, and weight gain. It has been recommended for the treatment of pain from spinal cord injury, fibromyalgia, lumbar spinal stenosis, and chronic regional pain syndrome. Recommended trial period is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. If inadequate control of pain is found, a switch to another first-line drug is recommended. In this case the patient has been taking Fanatrex since at least May 2014 and has not obtained analgesia. There is inadequate pain control. Switching to another first-line drug is recommended. The request is not medically necessary.

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Chronic Pain.