

Case Number:	CM13-0020181		
Date Assigned:	10/11/2013	Date of Injury:	07/01/2010
Decision Date:	01/22/2014	UR Denial Date:	08/08/2013
Priority:	Standard	Application Received:	09/11/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and Cardiology, has a subspecialty in Cardiovascular Disease and is licensed to practice in Texas. 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 physician 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/services. He/She is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 55-year-old female who reported an injury on 07/01/2010. The patient is currently diagnosed with carpal tunnel syndrome status post right carpal tunnel release with residual pain, bilateral wrist De Quervain's tenosynovitis, and degenerative joint disease of the 1st carpometacarpal joint bilaterally. The patient was recently seen on 09/10/2013. The patient reported 7/10 pain with weakness, numbness, tingling, and radiating pain. Physical examination revealed tenderness to palpation at the first dorsal muscle compartment and at the carpal tunnel bilaterally, palpable tenderness at the bases of the 1st carpometacarpal joints, positive Tinel's and Phalen's testing bilaterally, diminished sensation to light touch over the median nerve distribution at the right upper extremity, 4/5 muscle strength, 2+ symmetrical deep tendon reflexes, and 2+ vascular pulses. Treatment recommendations included the continuation of current medications

IMR ISSUES, DECISIONS AND RATIONALES

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

Dicopanol (Diphenhydramine) 5mg/ml oral suspension 150 ml: 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 Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment.

Decision rationale: Official Disability Guidelines state over the counter medication such as diphenhydramine has been indicated for insomnia treatment. Diphenhydramine is a sedating antihistamine and has been suggested for a sleep aid. As per the clinical notes submitted, there is no clear indication for the use of this medication, as there is no documented history of insomnia or allergies to warrant the use. The medical necessity has not been established, therefore the request is non-certified.

Fanax (Gabapentin) 25mg/ml oral suspension 420ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-19.

Decision rationale: California MTUS Guidelines state, 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. As per the clinical notes submitted, the patient has maintained a diagnosis of carpal tunnel syndrome. However, there is no clear indication as to whether this patient has previously utilized this medication. There is also no evidence of a failure to respond to oral medication prior to the initiation of a suspension form of gabapentin. The medical necessity has not been established. As such, the request is non-certified.

Deprizine 15mg/ml oral suspension 250ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease to not require the use of a proton pump inhibitor. As per the clinical notes submitted, there is no documented history of gastrointestinal events. There is so no evidence of a cardiovascular disease or risk factors that would warrant the need for a proton pump inhibitor. There is also no indication that this patient is unable to tolerate tablet or capsule forms of this medication to warrant the use of a suspension. Based on the clinical information received, the request is non-certified