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| <b>Case Number:</b>   | CM13-0031520 |                              |            |
| <b>Date Assigned:</b> | 12/04/2013   | <b>Date of Injury:</b>       | 10/06/2006 |
| <b>Decision Date:</b> | 02/13/2014   | <b>UR Denial Date:</b>       | 09/25/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/03/2013 |

### 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 Anesthesiology and Pain Medicine and is licensed to practice in Florida. 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 52-year-old female who reported an injury on 10/06/2006. The patient is currently diagnosed with bilateral wrist carpal tunnel syndrome. The patient was seen by [REDACTED] on 07/17/2013. The patient reported ongoing complaints of 6-8/10 bilateral wrist and hand pain. Physical examination revealed tenderness to palpation over the carpal bones and over the thenar and hypothenar eminences, diminished range of motion bilaterally, diminished sensation to pinprick and light touch along the course of the median nerve distribution bilaterally, decreased motor strength in bilateral upper extremities secondary to pain, and 2+ deep tendon reflexes. Treatment recommendations included continuation of current medication.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Dicopanol 5mg/ml oral suspension 150ml:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18-19, 69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**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:** The Official Disability Guidelines state diphenhydramine is an over-the-counter sedating antihistamine that has been suggested for sleep aid. Tolerance seems to develop within a few days. Next day sedation has been noted as well as impaired psychomotor and cognitive function. As per the clinical notes submitted, there is no documentation of chronic insomnia that may warrant the need for a sedating antihistamine. Additionally, the long-term use of sedative medication is not recommended by the Official Disability Guidelines. The medical necessity has not been established. Therefore, the request for Dicopanol 5mg/ml oral suspension 150ml is non-certified.

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

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18-19, 69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-18.

**Decision rationale:** The California MTUS Guidelines state anti-epilepsy drugs are recommended for neuropathic pain. Gabapentin has been shown to be effective for diabetic painful neuropathy and post herpetic neuralgia and has been considered as a first line treatment for neuropathic pain. As per the clinical notes submitted, the patient is diagnosed with bilateral carpal tunnel syndrome. Despite the ongoing use of this medication, the patient continues to report persistent 6-8/10 pain, activity limitation, numbness, tingling, and radiating pain. Satisfactory response to treatment has not been indicated. Therefore, ongoing use cannot be determined as medically appropriate. As such, the request for Fanatrex 25mg/ml oral suspension 420ml is non-certified.

**Deprizine 15mg/ml oral suspension 250ml:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18-19, 69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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

**Decision rationale:** The California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factors and no cardiovascular disease do not require the use of a proton pump inhibitor. As per the clinical notes submitted, the patient does not currently meet criteria for a proton pump inhibitor, as there is no documentation of gastrointestinal events, nor documentation of a cardiovascular disease or significant risk factors for gastrointestinal disorder. Therefore, the request for Deprizine 15mg/ml oral suspension 250ml is non-certified