

Case Number:	CM14-0018390		
Date Assigned:	04/18/2014	Date of Injury:	04/01/2012
Decision Date:	06/30/2014	UR Denial Date:	02/04/2014
Priority:	Standard	Application Received:	02/13/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in California. 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/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:

This 46-year-old patient sustained an injury on 4/1/12. The patient continues to receive ongoing treatment for chronic symptoms of right wrist and hand pain. The diagnoses include right carpal tunnel syndrome; trigger of right finger status post trigger finger release; anxiety disorder/mood/stress; and sleep disorder. The report of 1/2/14 from the provider noted the patient complained of right wrist, hand pain rated at 8/10 with constant triggering finger pain rated at 4-5/10. The medications offer temporary relief of pain and improve ability to have restful sleep. Exam showed tenderness of right carpal tunnel and first dorsal extensor muscle compartment; positive Tinel's over wrist; negative Finkelstein's and negative Phalen's; right ring finger with healed incision at ring digit from trigger release surgery; tenderness over A1 pulley and metacarpophalangeal joints (MCP) of 5th digit; sensation diminished along median nerve distribution; diffuse decrease in myotomes C5-T1. Reviews of the documents indicated urine drug screen dated 2/18/14 noted inconsistent finding for negative hydrocodone without change in treatment plan addressing aberrancy. The request(s) for synapryn 10mg/1ml oral suspension 500ml, Tabradol 1mg/ml oral suspension 250ml, Deprizine 15mg/ml oral suspension 250ml, Fanatrex 25mg oral suspension 150ml were non-certified on 2/5/14 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE (1) PRESCRIPTION FOR SYNAPRYN 10MG/1ML ORAL SUSPENSION 500ML:
Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79, 80. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES , ,

Decision rationale: Per the MTUS Guidelines, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant therapies, psychological support, and active treatments (e.g., exercise). The submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or returned to work status. There is no evidence presented of random drug testing or utilization of pain contract to adequately monitor for narcotic safety, efficacy, and compliance. The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with persistent severe pain. In addition, the submitted reports have not adequately demonstrated the specific indication to support for Synapryn oral suspension with active ingredient, Tramadol over oral pills, especially given inconsistent urine drug screen results. As such, the request is not medically necessary and appropriate.

ONE (1) PRESCRIPTION FOR TABRADOL 1MG/ML ORAL SUSPENSION 250ML:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available)..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANT Page(s): 63.

Decision rationale: Per MTUS Chronic Pain Guidelines on muscle relaxant, it is not recommended for mild to moderate chronic persistent pain problems including chronic pain (other than for acute exacerbations) due to the high prevalence of adverse effects in the context of insufficient evidence of benefit as compared to other medications. The submitted reports have no demonstrated spasm or neurological deficits to support for continued use of a muscle relaxant for this 2012 injury. Due to the unchanged objective findings without demonstrated evidence of acute muscle spasm, the indication and necessity for continued use of muscle relaxant has not been adequately addressed to warrant continued treatment regimen. The MTUS guidelines do not recommend long-term use of this muscle relaxant for this chronic injury. As such, the request is not medically necessary and appropriate.

ONE (1) PRESCRIPTION FOR 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 NSAIDS, GI SYMPTOMS AND CARDIOVASCULAR RISK, Page(s): 68-69.

Decision rationale: Per MTUS guidelines, Deprizine has active ingredient, Ranitidine, a medication prescribed for treatment of the problems associated with erosive esophagitis from Gastroesophageal reflux disease (GERD), or in patients with hyper-secretion diseases. Per MTUS Chronic Pain Treatment Guidelines, the patient does not meet criteria for Ranitidine namely reserved for patients with history of prior gastrointestinal (GI) bleeding, the elderly (over 65 years), diabetics, and chronic cigarette smokers. The submitted reports have not described or provided any GI diagnosis that meets the criteria to indicate medical treatment nor any indication that require medication to be in an oral suspension form. Reviews of the records show no documentation of any history, symptoms, or GI diagnosis to warrant treatment with this oral suspension. As such, the request is not medically necessary and appropriate.

ONE (1) PRESCRIPTION FOR FANATREX 25MG ORAL SUSPENSION 150ML:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines - EPILEPSY DRUGS/GABAPENTIN Page(s): 18-19.

Decision rationale: Although, Fanatrex oral suspension which has the active ingredient for the anti-epileptic medication, Gabapentin, has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain; however, submitted reports have not adequately demonstrated the specific indication to support for Fanatrex oral suspension over oral pills or its functional benefit from treatment previously rendered. As such, the request is not medically necessary and appropriate.