

Case Number:	CM15-0069713		
Date Assigned:	04/17/2015	Date of Injury:	09/17/2006
Decision Date:	07/13/2015	UR Denial Date:	04/09/2015
Priority:	Standard	Application Received:	04/13/2015

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: Pennsylvania

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 58 year old female with an industrial injury dated September 17, 2006. The injured worker diagnoses include bilateral wrist carpal tunnel syndrome, bilateral wrist triangular fibrocartilage complex (TFCC) tear, bilateral wrist scapholunate ligament tear, and status post left thumb laceration. Treatment consisted of diagnostic studies, prescribed medications, and periodic follow up visits. In a progress note dated 2/20/2015, the injured worker reported burning bilateral wrist pain and muscle spasms. The injured worker rated her pain a 6/10. The injured worker also reported weakness, numbness, tingling, and pain radiating to hand and fingers. Objective findings revealed tenderness to palpitation over the carpal bones and over thenar and hypothenar eminence bilaterally. Bilateral wrist exam revealed decrease active range of motion. Left thumb exam revealed tenderness to palpitation at the base of the left thumb. The treating physician prescribed a retrospective request for Synapryn, Tabradol, Deprizine, Dicopanol and Fanatrex for date of service 2/20/2015 now under review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Synapryn, 10 mg/ml oral suspension, 500 ml, provided on February 20, 2015: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Glucosamine Page(s): 50 and 74-96.

Decision rationale: Synapryn is a compounded combination of tramadol and glucosamine. Tramadol is classified as an opioid. According to the MTUS guidelines, determination for the use of opioids should not focus solely on pain severity but should include the evaluation of a wide range of outcomes including measures of functioning, appropriate medication use, and side effects. The guidelines state that measures of pain assessment that allow for evaluation of the efficacy of opioids and whether their use should be maintained include the following: 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 last. The criteria for long term use of opioids (6-months or more) includes among other items, documentation of pain at each visit and functional improvement compared to baseline using a numerical or validated instrument every 6 months. Opioids should be continued if the patient has returned to work and if there is improved functioning and pain. In this case, there was no documentation of any reduction in pain or improvement in function in response to opioid use. There was also no documentation of presence or absence of side effects or aberrant behavior in regards to opioid use. Glucosamine is recommended for moderate osteoarthritis pain, especially of the knee. This worker does not have a diagnosis of osteoarthritis for which glucosamine may be indicated and therefore the requested treatment is not medically necessary.

Tabradol 1 mg/ml oral suspension, 250 ml, provided on February 20, 2015: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 41 - 42.

Decision rationale: Tabradol contains cyclobenzaprine which is an anti-spasmodic used to decrease muscle spasm. Antispasmodics are often used to treat pain even in the absence of spasm. However cyclobenzaprine is not recommended for use longer than 2-3 weeks. It is recommended for acute exacerbations of chronic low back pain but is not recommended for chronic use. There is no indication in the record of an acute exacerbation of pain. It appears this medication is being prescribed for chronic pain which is not appropriate or medically necessary.

Deprizine 15 mg/ml oral suspension 250 ml, provided on February 20, 2015: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: Deprizine is ranitidine. Neither the MTUS or ODG mention ranitidine but in this case the ranitidine is being used for the same purpose as a proton pump inhibitor for the prevention of NSAID induced gastrointestinal effects. The MTUS provides a list of risk factors for gastrointestinal events for someone on an NSAID. These risks include age >65, history of peptic ulcer disease, GI bleeding or perforation, concurrent use of aspirin, corticosteroid, and/or an anticoagulant, or high dose/multiple NSAID. There is no documentation of any of these risk for which prophylaxis is necessary. Furthermore, if prophylaxis was necessary for NSAID induced gastrointestinal side effects, a PPI is indicated, not ranitidine, therefore making the requested treatment medically unnecessary.

Dicopanol (dyphenhydramine) 25 mg/ml oral suspension, 150 ml, provided on February 20, 2015: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. 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) Mental Illness and Stress: Insomnia.

Decision rationale: Diphenhydramine is an over the counter sedating antihistamine that is used as a sleep aid. However tolerance develops within a few days. The effects last into the following day and include impaired psychomotor and cognitive function. This medication is not appropriate or medically necessary for chronic use.

Fanatrex (gabapentin) 25 mg/ml oral suspension 420 ml, provided on February 20, 2015: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs Page(s): 18.

Decision rationale: According to the MTUS Gabapentin is recommended as first line treatment for neuropathic pain. This worker has a diagnosis of carpal tunnel syndrome with burning pain and numbness in the hand consistent with neuropathic pain. This worker has neuropathic pain for which gabapentin is appropriate. Fanatrex is a liquid form of gabapentin and is not a compounded medication and is medically necessary.