

Case Number:	CM14-0117452		
Date Assigned:	08/06/2014	Date of Injury:	02/03/2011
Decision Date:	11/19/2014	UR Denial Date:	06/25/2014
Priority:	Standard	Application Received:	07/25/2014

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 Internal Medicine 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:

The injured worker is a 58-year-old female who reported injury on 02/03/2011 due to repetitive squeezing and grasping while operating school buses through the years. The injured worker has diagnoses of chronic right dominant thumb carpometacarpal joint arthritis and low back pain. Medical treatment consists of occupational therapy, cortisone injections, acupuncture and medication therapy. The injured worker has undergone MRIs and x-rays of her right hand. On 02/17/2014, the injured worker complained of right hand pain. Range of motion of the wrist revealed a dorsiflexion of 60 bilaterally, palmer flexion 80 degrees bilaterally, radial deviation 20 degrees bilaterally and ulnar deviation of 30 degrees bilaterally. The injured worker had a motor strength of 5/5 bilaterally with wrist extensors and wrist flexors. Sensation was normal bilaterally. The treatment plan is for the injured worker to continue the use of medications. The provider feels she may be a candidate for either CMC joint fusion or resection arthroplasty. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Synapryn 10mg/1ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 76-81, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (Tramadol), Page(s): page(s) 78,93-94..

Decision rationale: The request for Synapryn 10 mg/1 mL is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines state that central analgesic drugs, such as Synapryn, are reported to be effective in managing neuropathic pain and it is not recommended as a first line oral analgesic. The California MTUS Guidelines recommend there should be documentation of the 4 A's for ongoing monitoring, to include analgesia, activities of daily living, adverse side effects and aberrant drug taking behaviors. The MTUS Guidelines also state that there should be a current pain assessment that should include 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 lasts. Furthermore, there should also be the use of drug screening or inpatient treatment with issues of abuse, addiction or poor pain control. As per the guideline recommendations state that Synapryn is not recommended as a first line oral analgesic. The submitted report lack any information suggesting that the injured worker had neuropathic pain. The report also lacked any evidence of the effectiveness of the medication. Furthermore, there were no notes suggesting what pain levels were before, during and after the medication. Additionally, there was no documentation of the 4 A's. There was a drug screen submitted on 03/03/2014, showing that the injured worker was in compliance with the MTUS Guidelines. However, the efficacy of the medication was not submitted in the report for review. The submitted documentation also did not submit a rationale as to why the injured worker would require liquid versus tablet medications. The request, as submitted, did not indicate a frequency or duration of the medication. Given that the documentation submitted for review lacked evidence, the request for Synapryn is not medically necessary.

Tabradol 1mg/1ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (For Pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Cyclobenzaprine (Tabradol), Page(s): page(s) 63-64..

Decision rationale: The request for Tabradol 1 mg/1 mL is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbation in patients with chronic low back pain. Efficacy appears to diminish over time and prolonged use of some medications in this class may lead to dependence. The MTUS Guidelines also state that despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Limited, mixed evidence on Tabradol does not allow for a recommendation for chronic use. This medication is not recommended to be used for longer than 2 to 3 weeks. The request, as submitted, did not specify the frequency or duration of the medication. There was also no quantified information regarding pain relief. The efficacy of the medication was not submitted for review. Additionally, there was no documentation as to whether the above medication helped with the injured worker's functional deficits. The

submitted documentation also noted that the injured worker had been on Tabradol since at least 02/01/2014, exceeding the recommended 2 to 3 weeks. The submitted documentation also lacked an assessment regarding current pain on VAS, which would include average pain, intensity of pain or longevity of pain. Given the above, the request for ongoing use of Tabradol is not supported by the California MTUS Guidelines. As such, the request is not medically necessary.

Deprizine 15mg/ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID'S, GI Symptoms & Cardiovascular Risk Page(s): 69.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Drugs.com, Deprizine (ranitidine hydrochloride).

Decision rationale: The request for Deprizine 15 mg/mL is not medically necessary. The MTUS/ACOEM and ODG do not address this medication. As such, Drugs.com was used as reference. According to Drugs.com, Deprizine is a histamine 2 blocker. It is used in the treatment of GERD and other conditions in which acid backs up from the stomach into the esophagus. Using Deprizine may increase your risk of developing pneumonia. Symptoms of pneumonia include chest pain, fever, feeling short of breath and coughing up green or yellow mucus. The submitted documentation did not indicate that the injured worker had any complaints of dyspepsia with the use of medication, cardiovascular disease or significant risk factors for gastrointestinal events. The submitted report also lacked any evidence as to how long the injured worker had been using any type of NSAID medication. Additionally, the efficacy of the medication was not submitted for review. Furthermore, the submitted report lacked any indication as to why the injured worker would require liquid versus tablet medications. In the absence of this documentation, the request is not supported by the evidence based guidelines. The request, as submitted, did not indicate a frequency or duration of the medication. As such, the request for Deprizine 15 mg/mL is not medically necessary.

Dicopanol 5mg/ml: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Antihistamines, Mental Illness and Stress, Insomnia (Dicopanol).

Decision rationale: The request for Dicopanol 5 mg/mL is not medically necessary. The Official Disability Guidelines state that sedating antihistamines have been suggested for sleep aids, tolerance seems to develop within a few days and next day sedation has been noted, as well as impaired psychomotor and cognitive function. Sedating antihistamines have been shown to

build tolerance against sedation effectiveness very quickly. The Official Disability Guidelines further state compounded medications should include at least 1 drug substance (or active ingredient) that is the sole active ingredient in an FDA approved prescription drug, not to include OTC drugs. The guidelines note compounded medications should include only bulk ingredients that are components of FDA approved drugs that have been made in an FDA registered facility and NDC and should not include any drug that was withdrawn or removed from the market for safety reasons and is not a copy of a commercially available FDA approved drug product. The guidelines also note that medication should include only drug substances that have been reported as safe and effective for the prescribed indication by the FDA approval process and/or by adequate medical and scientific evidence in medical literature. The provider's rationale for the use of the medication was not submitted for review. It is unclear as to why the injured worker would require compounded oral suppression medications as opposed to non-compounded traditional oral medications. Furthermore, the request, as submitted, did not indicate a frequency or duration of the medication. As such, the request for Dicopanol 5 mg/mL is not medically necessary.

Fanatrex 25mg/ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs Page(s): 18-19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs), Page(s): 16-22..

Decision rationale: The request for Fanatrex 25 mg/mL is not medically necessary. The California MTUS Guidelines state gabapentin (Fanatrex) has been shown to be effective for diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first line treatment for neuropathic pain. After initiation of treatment there should be documentation of pain relief and improvement in function, as well as, documentation of side effects incurred with the use of the medication. The continuous use of AEDs depends on improved outcomes versus tolerability of adverse effects. The injured worker was prescribed Fanatrex since at least 02/01/2014. The efficacy of the medication was not submitted for review. Furthermore, the provider's rationale was not provided. Additionally, the medical documents did not indicate that the injured worker had any difficulties taking traditional tablet medications which would indicate the injured worker's need oral suspension medications. The request, as submitted, did not indicate a frequency or duration. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request for Fanatrex 25 mg/mL is not medically necessary.