MAXIMUS Federal Services

Case Number:	CM13-0002638		
Date Assigned:	04/23/2014	Date of Injury:	09/15/2011
Decision Date:	06/12/2014	UR Denial Date:	07/09/2013
Priority:	Standard	Application Received:	07/23/2013

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 & Rehabilitation, has a subspecialty in Pain 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 patient is a 46 year old female who was injured on 09/14/2011 with an unknown mechanism of injury. The patient underwent removal, revision and replacement of spinal cord stimulator leaks on 03/27/2013; trial lead implantation for spinal cord stimulation on 02/13/2013; and the patient underwent sympathetic nerve block on 07/18/2012. There are no diagnostic studies for review. PR-2 dated 07/01/2013 indicates the patient received a stimulator trial implant in the past month. There are no objective findings documented for this visit. The patient is diagnosed with reflex sympathetic dystrophy of the lower limb, pain in the left ankle joint and left foot, and lumbar pain with radiculopathy. PR-2 dated 06/13/2013 reports the patient has complaints of back pain with bilateral leg pain and bilateral ankle and pain in bilateral feet. The pain is sharp, stable, aching, and cramping. She rates her pain from 1/10 to 10/10. Objective findings on exam revealed +1 swelling of lower extremity bilaterally. The patient's medications as of 08/28/2012 include Kadian 20 mg, Dilaudid 8 mg, hydrocodone, acetaminophen, Zolpidem, Gabapentin, Cymbalta and Terazosin hydrochloride 10 mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

30 CAPSULES OF TERAZOSIN HYDROCHLORIDE 10MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 37-38.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRPS MEDICATIONS Page(s): 38.

Decision rationale: According to the CA MTUS guidelines, Terazosin is recommended for sympathetically maintained pain (SMP). The medical records document the patient was diagnosed with reflex sympathetic dystrophy of the low limb, pain in left ankle joint and left foot and lumbar back pain with radiculopathy. The patient has been on Terazosin since 8/28/2012. In the absence of documented clear improvement of pain and function particularly on this medication, the request is not medically necessary according to the guidelines.

90 TABLETS OF DILAUDID 8MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 86-87.

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

Decision rationale: According to the CA MTUS guidelines, hydromorphone "Dilaudid" is recommended for intermittent or breakthrough pain. The medical records document the patient was diagnosed with reflex sympathetic dystrophy of the low limb, pain in left ankle joint and left foot and lumbar back pain with radiculopathy. The patient has been on hydromorphone since 8/28/2012. In the absence of documented clear improvement of pain and function particularly on this medication, absence of UDT for medication compliance, and as this medication is not indicated for long-term treatment, the request is not medically necessary according to the guidelines.

60 CAPSULES OF KADIAN 20MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 86-87.

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

Decision rationale: According to the CA MTUS guidelines, Morphine "Kadian" is recommended as it is they stabilize opioid medication levels, and provide around-the-clock analgesia. The medical records document the patient was diagnosed with reflex sympathetic dystrophy of the low limb, pain in left ankle joint and left foot and lumbar back pain with radiculopathy. The patient has been on hydromorphone since 8/28/2012. In the absence of documented clear improvement of pain and function particularly on this medication, and absence of UDT for medication compliance, the request is not medically necessary according to the guidelines.