

Case Number:	CM13-0008245		
Date Assigned:	02/03/2014	Date of Injury:	05/09/2002
Decision Date:	04/22/2014	UR Denial Date:	08/01/2013
Priority:	Standard	Application Received:	08/07/2013

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 Internal Medicine, and is licensed to practice in California and Illinois. 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 64 year old female who was injured on 5/9/02 while she was moving a 45 pound digital display screen. Prior treatment history has included injections. Her medication history includes Methadone, Morphine ER, Aspirin, Advil, MS-Contin, Zoloft, Tamoxifen, Tylenol, Levothyroxine, Neurontin, Effexor XR, and Lidoderm patches. Her history also includes fish oil, and kelp supplements. An EMG performed on 6/8/06 that revealed a nerve entrapment at the right wrist. An x-ray and CT scan were normal. A follow-up note dated 11/4/13 documented the patient to have complaints of right hand pain rated at 7/10 on the visual analog scale. Objective findings on exam revealed decreased range of motion to the right. She has right cervical C7 and T1 tenderness and right levator scapular muscle tenderness to palpation. She tolerates gentle palpation of the right hand. She exhibits mild pain behavior when she signs her name. She is unable to fully extend all the fingers of her right hand. She has minimal dilatation in her right hand. She has very limited strength in the right hand due to pain and some weakness not due to pain. She has some atrophy of the right thenar muscles with 2+ weakness of the thumb abduction. She is unable to reach and touch her face or head due to right shoulder and arm pain. Neuro exam reveals sensation to sharp stick versus cotton swab is decreased in the right hand. She also has sensation decreased in her right arm. The patient was diagnosed with severe chronic right hand pain, complex regional pain syndrome in the right hand, and right arm and neck myalgia. The treatment plan for the patient includes Methadone 10mg, Morphine Sulfate IR 15mg, Gabapentin 600mg, Effexor 150 XR, and Voltaren Gel 1%. A recommendation was given for an infrared bulb and lamp and exposes her right hand to gentle warmth.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF MS CONTIN ER 30MG, #90 BETWEEN 7/3/13 AND 9/27/13:

Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN, CRPS, MEDICATIONS

Decision rationale: Guidelines state that morphine sulfate controlled, extended, and sustained-release preparations should be reserved for patients with chronic pain who are need of continuous treatment. The guidelines state there are no long term studies demonstrating efficacy of opioids as treatment for complex regional pain syndrome. Opioids are a second- or third-line choice for patients failing other pharmacologic interventions with the understanding that long-term use can actually worsen allodynia and/or hyperalgesia. The medical records do not substantiate failure of other pharmacologic interventions. The medical necessity of MS Contin is not established.

PRESCRIPTION OF EFFEXOR XR 150MG, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EFFEXOR (VENLAXAFINE).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRPS TREATMENT AND SNRIs (SEROTNIN NORADRENALINE REUPTAKE INHIBITORS Page(s): 41,105. Decision based on Non-MTUS Citation Official Disability Guidelines.

Decision rationale: Effexor is an antidepressant in the class called selective serotonin and norepinephrine reuptake inhibitors (SNRIs). Guidelines state that SNRIs are recommended as an option in first-line treatment of neuropathic pain, especially if tricyclics are ineffective, poorly tolerated, or contraindicated. This medication has FDA approval for the treatment of depression and anxiety disorders. However, the medical records do not establish that tricyclics are not a viable option for this patient, or even that a diagnosis of depression or anxiety currently exists. The medical necessity of Effexor is not established.

PRESCRIPTION OF GABAPENTIN 600MG, #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRPS TREATMENT Page(s): 41. Decision based on Non-MTUS Citation Official Disability Guidelines

Decision rationale: According to the guidelines, Gabapentin has been recommended as a trial for treating complex regional pain syndrome (CRPS). According to the medical records, the patient is being treated for CRPS of the right hand. The guidelines support that Gabapentin is an appropriate medication that can be beneficial in diminishing the symptoms related to this condition. The medical necessity of this medication has been sufficiently established. However, continued use would require detailed documentation of objective improvement with utilization, which was not included in the records provided for review. The medical necessity of Gabapentin is not established.

ONE INFRARED LAMP AND BULB: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN, PHYSICAL MEDICINE TREATMENT; KNEE, DURABLE MEDICAL EQUIPMENT

Decision rationale: Durable medical equipment is recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. A heat lamp and bulb does not meet such criteria. Furthermore, in treatment of complex regional pain syndrome, the guidelines recommend continued active range of motion, stress loading, isotonic strengthening, general aerobic conditioning, and postural normalization. The medical literature does not substantiate an at-home heat source device is medically necessary for the management of the patient's injury. The medical necessity of an infrared lamp and bulb is not established.