

Case Number:	CM13-0010452		
Date Assigned:	09/20/2013	Date of Injury:	06/02/2003
Decision Date:	03/18/2014	UR Denial Date:	07/25/2013
Priority:	Standard	Application Received:	08/14/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas. He/she has been in active clinical practice for more than five years and is currently working least at 24 hours a week in active practice. The physician 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 63-year-old male who reported an injury on 06/02/2003. The mechanism of injury was not specifically stated. The patient is diagnosed with reflex sympathetic dystrophy of the right upper extremity, right wrist, hand, and elbow strain, right shoulder strain, secondary depression/insomnia, and secondary hypertension and cardiac dysfunction. The patient was seen by [REDACTED] on 07/02/2013. The patient reported persistent right upper extremity pain and swelling, as well as depression, headaches, difficulty sleeping, and neck pain. Physical examination revealed normal deep tendon reflexes of the upper extremities, decreased sensation, tenderness to palpation of the cervical muscles, minimal swelling from the midforearm to the right hand, discoloration of the skin, severe dysesthesia in the right upper limb, limited range of motion, mild tenderness noted over the forearm and hand, and moderate tenderness of the right shoulder. Treatment recommendations included pain management consultation, continuation of current medications including Norco, Opana ER, Neurontin, Fioricet, Protonix, Ambien, and Cymbalta and continuation of home exercises.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #150: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain, increasing headaches, difficulty sleeping, and neck pain. The patient also reports ongoing difficulty with activities of daily living. Satisfactory response to treatment has not been indicated by decrease in pain level, increase in function, or improved quality of life. Therefore, continuation cannot be determined as medically appropriate. As such, the request is non-certified.

Fioricet #60: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Barbiturate-containing analgesic agents (BCAs)

Decision rationale: Official Disability Guidelines state barbiturate containing analgesic agents are not recommended for chronic pain. Fioricet is commonly used for acute headache with some data to support it, but there is a risk of medication overuse, as well as rebound headache. As guidelines do not recommend use of this medication, the current request cannot be determined as medically appropriate. Additionally noted, the patient has continuously utilized this medication. Despite ongoing use, the patient continued to report increasing headaches. Based on the clinical information received and Official Disability Guidelines, the request is non-certified.

Opana ER 10mg #20: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain, increasing headaches, difficulty sleeping, and neck pain. The patient also reports ongoing difficulty with activities of daily living. Satisfactory response to treatment has not been

indicated by decrease in pain level, increase in function, or improved quality of life. Therefore, continuation cannot be determined as medically appropriate. As such, the request is non-certified.

Neurontin 300mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-18.

Decision rationale: California MTUS Guidelines state anti-epilepsy drugs are recommended for neuropathic pain. Gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain, increasing headaches, difficulty sleeping, and activity limitation. Satisfactory response to treatment has not been indicated. Therefore, the request is non-certified.

Protonix 40mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a non-selective NSAID. As per the documentation submitted, there is no evidence of cardiovascular disease or increased risk for gastrointestinal events. Therefore, the patient does not meet criteria for the requested medication. As such, the request is non-certified.

Ambien 10mg: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment

Decision rationale: Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for short-term treatment of insomnia with difficulty of

sleep onset. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report difficulty sleeping. There is no evidence of failure to respond to non-pharmacologic treatment prior to the initiation of a prescription product. As guidelines do not recommend long-term use of this medication, the current request cannot be determined as medically appropriate. Therefore, the request is non-certified.

Soma 350mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66 and 124.

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as non-sedating second-line options for short-term treatment of acute exacerbations in patients with chronic low back pain. Soma should not be used for longer than 2 to 3 weeks. The patient has continuously utilized this medication. Despite ongoing treatment, the patient continues to report persistent pain in the right upper extremity, neck pain, right shoulder pain, difficulty sleeping, and increased headaches with activity limitation. The patient's physical examination does not reveal palpable muscle spasm, muscle tension, or spasticity. As guidelines do not recommend long-term use of this medication, the current request is not medically appropriate. As such, the request is non-certified.