

Case Number:	CM13-0010689		
Date Assigned:	04/23/2014	Date of Injury:	04/23/2004
Decision Date:	07/25/2014	UR Denial Date:	07/16/2013
Priority:	Standard	Application Received:	08/13/2013

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 Occupational 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 62-year-old male who has filed a claim for chronic regional pain syndrome of the left upper extremity and major depressive disorder associated with an industrial injury date of April 23, 2004. Review of progress notes indicates left shoulder and left upper extremity pain. Findings include decreased painful range of motion, presence of guarding, and hypersensitivity to touch. There was marked swelling of the left hand with cooler temperature and discoloration. The patient attends monthly individual psychotherapy sessions. Patient reports preoccupation with hand/arm symptoms, and fear that something negative can happen to those body parts; fear of being abandoned; tension; sadness; anger; feelings of worthlessness, loneliness, and hopelessness; guilt; despair; isolation sleep disturbance; and death wishes. Findings include psychomotor retardation, slumped posture, delayed and prolonged speech, occasional tearfulness, and limited content of thought focused on physical symptoms. Patient has a history of suicidal ideation and self-inflicted laceration to the left arm. Treatment to date has included NSAIDs, muscle relaxants, gabapentin, anti-depressants, sedatives, topical analgesics, stellate ganglion injections, physical therapy, and chiropractic therapy, psychiatric therapy, left arm surgery, and left shoulder arthroscopy in July 2005 with post-operative physical therapy. Utilization review from July 16, 2013 denied the request for Prilosec 40mg (#30). There was modified certification for Cymbalta 60mg (#60); lorazepam 0.5mg (#90); gabapentin 600mg (#180); Nortriptyline 10mg (#60); triazolam 0.25mg (#12); and biweekly office visits for 12 months for 6 months. Reasons for denial and modification were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

CYMBALTA 60MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain and SNRIs (serotonin noradrenaline reuptake inhibitors) Page(s): 15, 105. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress chapter, Antidepressants for treatment of MDD (major depressive disorder).

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, SNRIs are recommended as an option in first-line treatment of neuropathic pain, especially if tricyclics are ineffective, poorly tolerated, or contraindicated. According to the ODG, antidepressants are recommended for initial treatment of presentations of Major Depressive Disorder (MDD) that are moderate, severe, or psychotic, unless electroconvulsive therapy is part of the treatment plan. This patient has been on this medication since September 2006. There is no recent documentation describing the symptoms of chronic regional pain syndrome of the left upper extremity. Progress notes indicate that the patient is in a severely depressed state, but there is no documentation as to the benefits derived from this medication, if any. Therefore, the request is not medically necessary.

LORAZEPAM 0.5MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. This patient has been on this medication since at least June 2007. Although the patient reports symptoms of anxiety and sleep difficulties, this medication is not recommended for long-term use. Therefore, the request is not medically necessary.

PRILOSEC 40MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, proton pump inhibitors are used in patients on NSAID therapy who are at risk for GI events. Risk factors include age > 65; history of peptic ulcer, GI bleed, or perforation; concurrent use of ASA, corticosteroids, or anticoagulant; and high dose or multiple NSAID use. Use of PPI > 1 year has been shown to increase the risk of hip fracture. This patient has been on this medication since January 2009. In this case, there is no documentation regarding the abovementioned conditions, or of upper GI symptoms, to support this request. Therefore, the request is not medically necessary.

GABAPENTIN 600MG: Upheld

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

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

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, gabapentin is useful for treating diabetic painful neuropathy and postherpetic neuralgia, and is considered first-line for neuropathic pain. This patient has been on this medication since at least November 2005. There is no documentation regarding symptomatic improvement or objective functional benefits derived from this medication. Therefore, the request is not medically necessary.

NORTRIPTYLINE 10MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-15. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress chapter, Antidepressants for treatment of MDD (major depressive disorder).

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines tricyclics are considered first-line agents for neuropathic pain, especially when accompanied by insomnia, anxiety, or depression. It is a possible option for non-neuropathic pain in depressed patients. According to the ODG, antidepressants are recommended for initial treatment of presentations of Major Depressive Disorder (MDD) that are moderate, severe, or psychotic, unless electroconvulsive therapy is part of the treatment plan. Many treatment plans start with SSRIs. In addition, other medications that are likely to be optimal for most patients include desipramine, Nortriptyline, bupropion, and Venlafaxine. This patient has been on this medication since at least January 2009. There is limited documentation regarding the patient's upper extremity complex regional pain syndrome (CRPS) to support the continued use of this medication. There is also no

documentation as to the psychological benefits derived from this medication. Therefore, the request is not medically necessary.

TRIAZOLAM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. This patient has been on this medication since May 2013. Although the patient reports symptoms of anxiety and sleep difficulties, this medication is not recommended for long-term use. Therefore, the request is not medically necessary.

TWENTY-FOUR (24) BI-WEEKLY OFFICE VISITS FOR 12-MONTHS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, gabapentin is useful for treating diabetic painful neuropathy and postherpetic neuralgia, and is considered first-line for neuropathic pain. This patient has been on this medication since at least November 2005. There is no documentation regarding symptomatic improvement or objective functional benefits derived from this medication. Therefore, the request is not medically necessary.