

<b>Case Number:</b>	CM13-0030857		
<b>Date Assigned:</b>	04/25/2014	<b>Date of Injury:</b>	07/19/2006
<b>Decision Date:</b>	07/25/2014	<b>UR Denial Date:</b>	09/17/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/01/2013

### 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 Family Medicine, and is licensed to practice in Arizona. 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:

Patient is a 53 year old male with a date of injury on 7/19/2006. Diagnoses include major depressive disorder, post Maddox stress disorder, chronic pain, pain in limb, disturbance of skin sensation, and hand crush injury. Subjective complaints are of upper extremity pain that is severe, and is helped by medications. Patient also reports some passive suicidal ideation. Physical exam shows allodynia and hyperpathia in the upper extremity and at the amputation site. Exam remains unchanged from previous. Medications include Voltaren gel, Neurontin, Norco, Ambien, Remeron, Cymbalta, and Butrans patch. Submitted documentation recommends that patient undergo a repeat stellate ganglion block. Medical records indicate that the patient has had prior psychotherapy which was helpful, and patient had been approved for 12 psychotherapy sessions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PRESCRIPTION OF BUTRANS (UNKNOWN DOSAGE AND QUANTITY):** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The patient in question has been on chronic opioid therapy. CA Chronic Pain Guidelines has specific recommendations for the ongoing management of opioid therapy. Clear evidence should be presented about the degree of analgesia, level of activity of daily living, adverse side effects, or aberrant drug taking behavior. For this patient, documentation shows stability on medication, increase functional ability, and no adverse side effects. Furthermore, documentation is present of MTUS opioid compliance guidelines, including risk assessment, and ongoing efficacy of medication. Therefore, the use of this medication is consistent with guidelines and is medically necessary for this patient.

**COGNITIVE THERAPY WITH PAIN PSYCHOLOGY:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PSYCHOLOGICAL TREATMENT, COGNITIVE BEHAVIOR THERAPY Page(s): 101, 23.

**Decision rationale:** CA MTUS recommends cognitive therapy for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders. Initial trial of 3-4 psychotherapy visits over 2 weeks and with evidence of objective functional improvement, a total of up to 6-10 visits over 5-6 weeks. For this patient, submitted documents indicate that patient has already been approved for and is attending 12 therapy sessions. Therefore, the medical necessity for cognitive therapy with pain psychology is not established.

**MEDICAL CLEARANCE : INCLUDING A PHYSICAL, EKG, AND LABS:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PAIN, OFFICE VISITS Other Medical Treatment Guideline or Medical Evidence: acc/aha 2007 guidelines Perioperative Cardiovascular Evaluation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) CHAPTER 7, PAGE 127.

**Decision rationale:** Guidelines recommend perioperative cardiovascularly evaluation and care for non-cardiac surgery in patients that are over 50 years of age. This patient is 53 year old and guidelines would recommend history and physical and cardiac evaluation to determine risk status for surgery. ACOEM guidelines indicated that consultation can be obtained to aid in diagnosis, prognosis, therapeutic management, and determination of medical stability. The ODG recommends that office visits be determined medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctors play a critical role in the proper

diagnosis and return to function of an injured worker, and they should be encouraged. Therefore, the requested preoperative evaluation is medically necessary.

**PRESCRIPTION OF NEURONTIN (UNKNOWN DOSAGE AND QUANTITY): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** CA MTUS indicates that gabapentin is an anti-seizure medication and is recommended for neuropathic pain. CA MTUS also adds that following initiation of treatment there should be documentation of at least 30% pain relief and functional improvement. The continued use of an AED for neuropathic pain depends on these improved outcomes. Review of the submitted medical records did not identify any documentation of pain relief or functional improvement with this medication. Therefore, the medical necessity for gabapentin is not established.

**PRESCRIPTION OF NORCO (UNKNOWN DOSAGE AND QUANTITY): Overturned**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The patient in question has been on chronic opioid therapy. CA Chronic Pain Guidelines has specific recommendations for the ongoing management of opioid therapy. Clear evidence should be presented about the degree of analgesia, level of activity of daily living, adverse side effects, or aberrant drug taking behavior. For this patient, documentation shows stability on medication, increase functional ability, and no adverse side effects. Furthermore, documentation is present of MTUS opioid compliance guidelines, including risk assessment, and ongoing efficacy of medication. Therefore, the use of this medication is consistent with guidelines and is medically necessary for this patient.

**PRESCRIPTION OF VOLTAREN GEL (UNKNOWN DOSAGE AND QUANTITY): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

**Decision rationale:** CA MTUS indicates that diclofenac gel can be used for relief of osteoarthritis pain in joints that lend themselves to treatment (ankle, foot, elbow, hand, and wrist). CA MTUS indicates that topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but with a diminishing effect over another 2-week period. Review of submitted documentation does not identify evidence of osteoarthritis. Therefore, the medical necessity of diclofenac gel is not established.