

<b>Case Number:</b>	CM13-0063869		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	05/10/2012
<b>Decision Date:</b>	03/27/2014	<b>UR Denial Date:</b>	12/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/10/2013

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Georgia. 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 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 claimant is a 36-year-old female presenting with right upper extremity pain following a work-related injury on May 10, 2012. On October 16, 2013 the claimant reported increasing pain in the right upper extremity and severe autonomic dysfunction with cold hand. The physical exam revealed right arm trauma, profound coldness, discoloring, diffuse hyperalgesia and allodynia in the upper extremity with weakness. Treatment on that date included medications and activity modification. The claimant was diagnosed with complex regional pain syndrome in the right upper extremity with prominent vasomotor dysfunction and severe pain, history of right wrist sprain/strain, history of nonindustrial recurrent bilateral pneumothorax with right apical resections and pleurodesis procedure completed by right eye ptosis from sympathetic chain injury requiring mullerectomy, lumbar spine contusion, right L5 cystic structure in the subarticular recess representing a nerve sheath tumor versus ganglion. Request was made for spinal cord stimulation trial right upper extremity with preoperative psychological clearance, and medications including Cialis 5 mg, Nuvigil, and medical marijuana.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**A spinal cord stimulator trial:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Complex Regional Pain Syndrome Page(s): 32.

**Decision rationale:** The spinal cord stimulator trial is not medically necessary. Per Ca MTUS spinal cord stimulator recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated, for specific conditions indicated below, and following a successful temporary trial. Although there is limited evidence in favor of Spinal Cord Stimulators (SCS) for Failed Back Surgery Syndrome (FBSS) and Complex Regional Pain Syndrome (CRPS) Type I, more trials are needed to confirm whether SCS is an effective treatment for certain types of chronic pain. The provider did note that sympathetic blockade was contraindicated but was lack of documentation that the claimant has adequately failed less invasive methods for example medications including anticonvulsant, antidepressants and alpha 2 agonists. Additionally, psychological clearance is required prior to a spinal cord stimulator trial, given the medical records noted that the claimant is not psychologically stable; therefore the requested procedure is not medically necessary.

**Cialis:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Complex Regional Pain Syndrome Page(s): 32.

**Decision rationale:** Cialis is not medically necessary. Per CA Medications for complex regional pain syndrome is recommended only as indicated below. Most medications have limited effectiveness. (Ribbers, 2003) (Quisel2, 2005) 1. Regional inflammatory reaction: Commonly used drugs are NSAIDS, corticosteroids and free-radical scavengers. There is some evidence of efficacy for topical DMSO cream, IV bisphosphonates and limited courses of oral corticosteroids. Corticosteroids are most effective when positive response is obtained with sympathetic blocks. NSAIDs are recommended but no trials have shown effectiveness in CRPS-I, and they are Chronic Pain Medical Treatment Guidelines 8 C.C.R. Â§Â§9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 38 of 127 recommended primarily in early or very late stages. (Stanton-Hicks, 2004) (Sharma, 2006) 2. Stimulus-independent pain: The use of antidepressants, anticonvulsants, and opioids has been primarily extrapolated based on use for other neuropathic pain disorders. (See Antidepressants for chronic pain; Anticonvulsants for chronic pain; & Opioids for neuropathic pain.) Mexiletine, lidocaine patches and capsaicin are used but efficacy is not convincing. For central inhibition opiates, Gabapentin, TCAs, GABA-enhancing drugs, and Clonidine may be useful. 3. Stimulus-evoked pain: treatment is aimed at central sensitization. With NMDA receptor antagonists (Ketamine and amantadine) convincing controlled trials are lacking, and these drugs are known for their side effects. 4. Sympathetically maintained pain (SMP): Î±1 adrenoceptor blocking agents (terazosin, prazosin, and phenoxybenzamine) have been shown to be effective in a case report. (Ghostine, 1984) Sympathetic suppressors such as guanethadine, reserpine, droperidol, or atropine (in general or IV block) have shown low effectiveness. (Perez, 2001) (Quisel2, 2005) Phentolamine (IV) has been used as an alternative to determine responsiveness to Î±1 adrenoceptor blocking agents. See

also Sympathetically maintained pain (SMP). 5. Treatment of bone resorption with bisphosphonate-type compounds and calcitonin. Significant improvement has been found in limited studies of intravenous clodronate and intravenous alendronate. Adendronate (Fosamax®) given in oral doses of 40 mg a day (over an 8 week period) produced improvements in pain, pressure tolerance and joint mobility. (Manicourt DH, 2004) Mixed results have been found with intranasal calcitonin (Miacalcin®). (Sahin, 2005) (Appelboom, 2002) (Rowbathan, 2006) (Sharma, 2006). Cialis is not a recommended medication for CRPS; therefore the request is not medically necessary.

### **Nuvigil:**

**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 Complex Regional Pain Syndrome Page(s): 32.

**Decision rationale:** Nuvigil is not medically necessary. Per Ca MTUS medications are recommended only as indicated below. Most medications have limited effectiveness. (Ribbers, 2003) (Quisel2, 2005) 1. Regional inflammatory reaction: Commonly used drugs are NSAIDS, corticosteroids and free-radical scavengers. There is some evidence of efficacy for topical DMSO cream, IV bisphosphonates and limited courses of oral corticosteroids. Corticosteroids are most effective when positive response is obtained with sympathetic blocks. NSAIDs are recommended but no trials have shown effectiveness in CRPS-I, and they are Chronic Pain Medical Treatment Guidelines 8 C.C.R. §§9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 38 of 127 recommended primarily in early or very late stages. (Stanton-Hicks, 2004) (Sharma, 2006) 2. Stimulus-independent pain: The use of antidepressants, anticonvulsants, and opioids has been primarily extrapolated based on use for other neuropathic pain disorders. (See Antidepressants for chronic pain; Anticonvulsants for chronic pain; & Opioids for neuropathic pain.) Mexiletine, lidocaine patches and capsaicin are used but efficacy is not convincing. For central inhibition opiates, Gabapentin, TCAs, GABA-enhancing drugs, and Clonidine may be useful. 3. Stimulus-evoked pain: treatment is aimed at central sensitization. With NMDA receptor antagonists (Ketamine and amantadine) convincing controlled trials are lacking, and these drugs are known for their side effects. 4. Sympathetically maintained pain (SMP): ±1 adrenoceptor blocking agents (terazosin, prazosin, and phenoxybenzamine) have been shown to be effective in a case report. (Ghostine, 1984) Sympathetic suppressors such as guanethadine, reserpine, droperidol, or atropine (in general or IV block) have shown low effectiveness. (Perez, 2001) (Quisel2, 2005) Phentolamine (IV) has been used as an alternative to determine responsiveness to ±1 adrenoceptor blocking agents. See also Sympathetically maintained pain (SMP). 5. Treatment of bone resorption with bisphosphonate-type compounds and calcitonin. Significant improvement has been found in limited studies of intravenous clodronate and intravenous alendronate. Adendronate (Fosamax®) given in oral doses of 40 mg a day (over an 8 week period) produced improvements in pain, pressure tolerance and joint mobility. (Manicourt DH, 2004) Mixed results have been found with intranasal calcitonin (Miacalcin®). (Sahin, 2005) (Appelboom, 2002) (Rowbathan, 2006) (Sharma, 2006). Nuvigil is not a recommended medication for CRPS; therefore the request is not medically necessary

**Medical marijuana:** 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  
Cannabinoids Page(s): 28.

**Decision rationale:** Medical Marijuana is not recommended. Per Ca MTUS, In total, 11 states have approved the use of medical marijuana for the treatment of chronic pain, but there are no quality controlled clinical data with cannabinoids. Restricted legal access to Schedule I drugs, such as marijuana, tends to hamper research in this area. It is also very hard to do controlled studies with a drug that is psychoactive because it is hard to blind these effects. At this time it is difficult to justify advising patients to smoke street grade marijuana, presuming that they will experience benefit, when they may also be harmed. (Mackie, 2007) (Moskowitz, 2007) One of the first dose-response studies of cannabis in humans has found a window of efficacy within which healthy volunteers experienced relief from experimentally induced pain. But although mid-range doses provided some pain relief, high doses appeared to exacerbate pain. (Wallace, 2007) Results of a double-blind crossover study suggest that smoked cannabis may reduce pain intensity for patients with neuropathic pain, although the Food and Drug Administration (FDA), Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Institute for Drug Abuse (NIDA) report that no sound scientific studies support the medicinal use of cannabis. Psychoactive effects were also seen, including feeling high, although these were less apparent at the lower dose. Of more concern, were effects on cognitive performance, which in this chronic pain population was at or below the threshold for impairment already at baseline. Cannabis use was associated with modest declines in cognitive performance, particularly learning and recall, especially at higher doses. The finding necessitates caution in the prescribing of medical marijuana for neuropathic pain, especially in instances in which learning and memory are integral to a patient's work and lifestyle. (Wilsey, 2008); therefore the requested medication is not medically necessary.