

Case Number:	CM13-0067099		
Date Assigned:	01/03/2014	Date of Injury:	03/29/2005
Decision Date:	05/20/2014	UR Denial Date:	12/06/2013
Priority:	Standard	Application Received:	12/17/2013

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 Emergency 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 has a date of injury of 3/29/05. No mechanism of injury provided. The patient has a diagnosis of reflex sympathetic dystrophy, pain shoulder joint, depression, and anxiety. Medical records reviewed were from primary treating physician and consults. Last report was available until 12/11/13. The patient continues to complain of chronic neck, shoulder and upper extremity pain. The pain is 7.5/10 with medication. The pain is located on the neck, both shoulders and head. The pain is described as shooting and burning. Clinical report mentions that patient reports improvement of pain from 9 to 7/10 with Cymbalta. The clinical reports also states that Celebrex helps with the pain. In addition, the patient continues to use Ambien to sleep at night. The patient reports undefined "benefit and improved function" with Nucynta. The patient has a pain contract and is getting urine drug screens although no results were provided. There are vague complaints of "gastrointestinal upset" secondary to use of oral medicines. Objective findings were a well appearing patient in no distress. Positive Finkelstein test on the right. Last full exam was from 9/4/13 which showed tenderness to palpation and myofascial spasms in cervical paraspinal muscles. Limited neck range of motion (ROM). Motor strength in upper extremity is intact although unable to extend right upper extremity beyond 60 degrees. Diffuse swelling in both hands and fingers. Mild tenderness to palpation around the left carpometacarpal (CMC) joint of thumb. Limited ROM of thumb due to pain. The patient had received De Quervain's injection on 11/5/13 that improved pain by 50%. The patient has undergone acupuncture with mild improvement. There is no documentation of any other treatment modalities attempted. Current medication include Cymbalta 20mg, Ketamine cream, capsaicin 0.075% cream, lidoderm 5% patch, protonix 20mg, Ambien CR 12.5mg, Celebrex 100mg, Flexeril 7.5mg, Nucynta 50mg, and Cartia XT. MRI (magnetic resonance imaging) of the lumbar spine (1/9/12) shows L4-5 degenerative disc with grade 1 spondylolisthesis, bilateral degenerative facet changes, minor L1-

2 disc bulge, degenerative facet arthropathy L4-S1 bilaterally and scoliosis. Electromyography (EMG) (5/3/12) of bilateral lower extremities was normal. Utilization review (UR) are for prescriptions for capsaicin 0.075% cream 60g #4, pantoprazole, cymbalta 20mg, ketamine 5% cream, lidoderm 5% patch, pantoprazole(protonix) 20mg #60, Ambien CR 12.5mg #30, celebrex 100mg #60 refill #5, cyclobenzaprine(flexeril) 7.5mg #90, Nucynta 50mg #90, Cartia XT 120mg, Hydrochlorthiazide 25mg, lorazepam 2mg, and Trazadone 150mg. Prior UR on 12/6/13 recommended non-certification for Capsacin, ketamine 5% cream, lidoderm patch, Ambien CR 12.5mg, Cartia XT 120mg and hydrochlorthiazide 25mg. Partial certification of Cymbalta 20mg to 3month supply, Pantoprazole (protonix) 20mg to 3month supply, Celebrex 100mg to 3month supply, partial certification of cyclobenzaprine (flexeril) 7.5mg to 3month supply, partial certification of Nucynta 50mg to 3month supply, Trazodone 150mg to 3month supply, and Lorazepam 2mg to 1month supply.

IMR ISSUES, DECISIONS AND RATIONALES

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

CAPSAICIN: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Capsaicin, topical Page(s): 28,29.

Decision rationale: The MTUS chronic pain guidelines recommend capsaicin as an option if other modalities are not effective. There is some evidence of efficacy in neuropathic conditions. However, as per MTUS guidelines, the dosage of 0.075% is considered a high and experimental dose and there is no evidence to support a dose beyond 0.025%. The request for the high dose of capsaicin is not medically necessary.

PANTOPRAZOLE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section non-steroidal anti-inflammatory drugs (NSAIDs), GI (gastrointestinal) symptoms and cardi.

Decision rationale: Pantoprazole is a proton-pump inhibitor (PPI) used for dyspepsia from non-steroidal anti-inflammatory drugs (NSAIDs), use or gastritis/peptic ulcer disease. As per MTUS guidelines, PPIs may be used in patients with high risk for gastric bleeds or problems or signs of dyspepsia in patients on NSAIDs. In this case, the patient has vague complaints of "gastrointestinal (GI) upset" which may be nausea or dyspepsia although documentation does not support either conclusion. The patient is also already on a COX-2 inhibitor (Celebrex) which decreases risk of dyspepsia. The patient does not meet MTUS criteria for use of PPI. As such, the request for Pantoprazole is not medically necessary.

CYMBALTA 20 MG: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Duloxetine (Cymbalta Page(s): 43-44.

Decision rationale: Cymbalta (Duloxetine) is an antidepressant and as per MTUS guidelines is recommended for neuropathic pain. There is documentation of some improvement when patient is taking this medication. The patient has a history of complex regional pain syndrome (CRPS) which is an indication for use of Cymbalta. Therefore, the request for Cymbalta is medically necessary.

KETAMINE 5% CREAM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Topical Analgesics Page(s): 111-113.

Decision rationale: As per MTUS guidelines, ketamine cream is under study and is only recommended when all primary and secondary treatments are exhausted. There is poorly controlled evidence to support its use in complex regional pain syndrome. While patient does have complex regional pain syndrome (CRPS), there is no documentation to support failure of other treatment modalities before the use of a poorly evidenced and off label, non- Food and Drug Administration (FDA) approved product. The request for Ketamine 5% cream is not medically necessary.

LIDODERM 5% PATCH: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Lidoderm(lidocaine patch), Page(s): 56-57.

Decision rationale: As per MTUS chronic pain guidelines, lidoderm is only approved for peripheral neuropathic pain, specifically post-herpetic neuralgia. There is poor evidence to support its use in other neuropathic pain conditions such as complex regional pain syndrome (CRPS) that patient has. As such, the request for Lidoderm 5% patch is not medically necessary.

PANTOPRAZOLE PROTONIX 20 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section non-steroidal anti-inflammatory drugs (NSAIDs), GI (gastrointestinal) symptoms and cardi.

Decision rationale: Pantoprazole is a proton-pump inhibitor (PPI) used for dyspepsia from non-steroidal anti-inflammatory drugs (NSAIDs), use or gastritis/peptic ulcer disease. As per MTUS guidelines, PPIs may be used in patients with high risk for gastric bleeds or problems or signs of dyspepsia in patients on NSAIDs. In this case, the patient has vague complaints of "gastrointestinal (GI) upset" which may be nausea or dyspepsia although documentation does not support either conclusion. The patient is also already on a COX-2 inhibitor (Celebrex) which decreases risk of dyspepsia. The patient does not meet MTUS criteria for use of PPI. As such, the request for Pantoprazole protonix 20mg is not medically necessary.

AMBIEN CR 12.5 MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: There is no specific section in the MTUS chronic pain or ACOEM guidelines that relate to this topic. Ambien is a benzodiazepine agonist approved for insomnia. The Official Disability Guidelines (ODG) recommends ambient for the treatment of underlying cause of sleep disturbance and recommend short course of treatment. In this case, the patient has been on Ambien chronically at least since 1/2013. There is no documentation of other conservative attempts at treatment of sleep disturbance or sleep studies. The patient's sleep problem is noted to be due to pain which should be the primary target for treatment to improve patient's sleep. There was a prior note mention weaning patient off this medication. The number of tablets of 30 is not appropriate for a weaning plan. The chronic use of Ambien is not medically appropriate and necessary.

CELEBREX 100 MCG: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section NSAIDs (non-steroidal anti inflammatory drugs), Page(s): 67-68.

Decision rationale: Naproxen is an NSAID (non-steroidal anti-inflammatory drug) and is a specific COX-2 inhibitor. As per MTUS Chronic Pain guidelines, there is poor evidence that NSAIDs may help with other sources of pain such as neuropathic or low back pains. The MTUS

guidelines recommend short course of treatment due to potential side effects. In this case, the patient has no documented osteoarthritis although the patient has some objectively documented improvement on NSAIDs with no reported side effects except for "gastrointestinal (GI) upset." The continuation use of celebrex is medically necessary. As such, the request is certified.

CYCLOBENZAPRINE FLEXERIL 7.5 MG: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Cyclobenzaprine (Flexeril), Page(s): 41-42.

Decision rationale: Flexeril is a muscle relaxant. The patient is reportedly already on this medication. As per MTUS guidelines, evidence show that it is better than placebo but is considered a second line treatment due to high risk of adverse events. Muscle relaxant is recommended only for short course of treatment for acute exacerbations. There is some evidence of benefit in patients with fibromyalgia. In this case, the patient has reported muscle spasms that are reportedly improved with flexeril. With the reported improvement in function and muscle spasms with flexeril, its continuation is recommended. As such, the request is certified.

NUCYNTA 50 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Opioids Page(s): 76-79.

Decision rationale: Nucynta is a synthetic opioids, Mu-agonist. As per MTUS chronic pain guidelines, there are specific guidelines concerning management of chronic pain with opioids that should be followed while patient is on opioids therapy. The patient meets criteria for maintenance of opioids for pain control. However, the MTUS guidelines recommend visits to treating physician every 2 weeks during the initial trial phase and then every 1-2 months and lengthened out as therapy is stabilized. The patient has only begun use of Nucynta for 2months and should be more closely monitored. While the use of Nucynta is medically appropriate, the large number of tablets provided by the prescription does not meet MTUS chronic pain guideline criteria for monitoring for treatment. Therefore the prescription for Nucynta with 90 tablets is not medically appropriate.

CARTIA XT 120 MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Drugs.com.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Diabetes (type 1,2 and gestational), Hypertension treatment

Decision rationale: There is no specific section in the MTUS chronic pain or ACOEM guidelines that relate to this topic. Cartia XT is a calcium channel antagonist used for the treatment of hypertension. As per Official Disability Guidelines (ODG), calcium channel blockers may be used for the treatment of hypertension. However, there is not a single documentation of patient being diagnosed with hypertension or a single vital signs showing hypertension. There is no documentation of how hypertension may be related to the patient's injury. Since there is no documentation of actual diagnosis of hypertension, the prescription for Cartia XT is not medically necessary.

HYDROCHLOROTHIAZIDE 25 MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Drugs.com

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Diabetes (type 1,2 and gestational), Hypertension treatment

Decision rationale: There is no specific section in the MTUS chronic pain or ACOEM guidelines that relate to this topic. Hydrochlorthiazide(HCTZ) is a Thiazide diuretic used for the treatment of HTN. As per Official Disability Guidelines (ODG), thiazide diuretics may be used for the treatment of hypertension. However, there is not a single documentation of patient being diagnosed with hypertension or a single vital signs showing hypertension. There is no documentation of how hypertension may be related to the patient's injury. Since there is no documentation of actual diagnosis of hypertension, the prescription for Hydrochlorothiazide is not medically necessary.

LORAZEPAM 2 MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Consult

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Behavioral interventions: Benzodiazepines Page(s): 23-24.

Decision rationale: Lorazepam is a benzodiazepine. In this case, the primary treating physicians records history of anxiety but there no provided documentation as to support reasoning as to why xanax is being prescribed. As per MTUS chronic pain treatment guidelines, lorazepam is not recommended. There is a high risk of dependence and tolerance. It may be considered in situations where there is overwhelming symptoms but there is no documentation of these symptoms and number of tabs prescribed does not support intermittent use. It is not recommended for anxiety and can worsen anxiety if used chronically. Anti-depressants and other

modalities is more appropriate for anxiety treatment. As such, the request for Lorazepam is not recommended.

TRAZADONE 150 MG: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Antidepressants for chronic pain, Page(s): 13-14.

Decision rationale: Trazadone is a SARI (Serotonin Agonist and Reuptake Inhibitor), a type of antidepressant. As per MTUS chronic pain guidelines, antidepressants are recommended for patients with neuropathic pain with concomitant depression. In this case, the patient meets criteria for both neuropathic pain treatment and for depression. As such, the request for Trazadone is medically necessary.