MAXIMUS Federal Services

Case Number:	CM14-0002648		
Date Assigned:	02/03/2014	Date of Injury:	01/18/2010
Decision Date:	06/20/2014	UR Denial Date:	12/17/2013
Priority:	Standard	Application Received:	01/08/2014

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 Anesthesiology, Pain Medicine and is licensed to practice in Florida 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 injured worker is a 42-year-old male who reported an injury on 01/18/2010. The mechanism of injury was not specifically stated. Current diagnoses include complex regional pain syndrome in the left upper extremity/neuropathic pain, status post repeat left stellate ganglion block under fluoroscopy on 09/26/2013, left shoulder impingement syndrome with adhesive capsulitis, history of left wrist arthroscopy with hardware placement, and insomnia secondary to pain. The injured worker was evaluated on 01/07/2014. The injured worker reported persistent pain in the left upper extremity. The injured worker was previously treated with 2 stellate ganglion blocks on 06/27/2013 and 09/26/2013. Previous conservative treatment also includes acupuncture treatment, 24 sessions of physical therapy, and a psychology evaluation. Current medications include naproxen, omeprazole, gabapentin, Norco, amitriptyline, Dendracin lotion, and Ambien. Physical examination revealed cervical paraspinous tenderness, marked tenderness over the left shoulder, positive allodynia over the dorsum of the left hand and wrist, moderate swelling over the left hand and wrist, positive hyperhidrosis, discoloration of the left upper extremity, and decreased sensation to light touch over the left thumb, index, and middle finger. Treatment recommendations included continuation of current medication and a possible intrathecal Prialt trial for complex regional pain syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE NORCO 10/325MG: Upheld

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

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

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has utilized Norco 10/325 mg since 05/2013. There is no evidence of objective functional improvement. There is also no frequency or quantity listed in the current request. Therefore, the request is not medically necessary.

NORCO 10/325MG: Upheld

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

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

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has utilized Norco 10/325 mg since 05/2013. There is no evidence of objective functional improvement. There is also no frequency or quantity listed in the current request. Therefore, the request is not medically necessary.

NAPROXEN 550MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 67-72.

Decision rationale: The California MTUS Guidelines state NSAIDS are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDS are recommended as a second line option after acetaminophen. The injured worker has utilized naproxen 550 mg since 05/2013. There is no evidence of objective functional improvement. There is also no frequency or quantity listed in the current request. Therefore, the requested is not medically necessary.

OMEPRAZOLE 20MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, NSAIDs, GI Symptoms & C.

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

Decision rationale: The 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 nonselective NSAID. There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the injured worker does not meet criteria for the requested medication. There is also no frequency or quantity listed in the current request. As such, the request is not medically necessary.

GABAPENTIN 600MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Antiepilepsy Drugs (AED.

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

Decision rationale: The California MTUS Guidelines state anti-epilepsy drugs are recommended for neuropathic pain. The injured worker has utilized gabapentin 600 mg since 10/2013. There is no evidence of objective functional improvement. There is also no frequency or quantity listed in the current request. As such, the request is not medically necessary.

AMITRIPTYLINE 50MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 13-16.

Decision rationale: The California MTUS Guidelines state antidepressants are recommended as a first line option for neuropathic pain and as a possibility for non-neuropathic pain. Amitriptyline is indicated for neuropathic pain. The injured worker has utilized amitriptyline since 05/2013. There is no evidence of objective functional improvement. There is also no frequency or quantity listed in the current request. Therefore, the request is not medically necessary.

RETROSPECTIVE DENDRACIN LOTION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Topical Analgesics.

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

Decision rationale: The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The injured worker has utilized Dendracin lotion since 05/2013, without any evidence of objective functional improvement. There is no frequency or quantity listed in the current request. Therefore, the request is not medically necessary.

DENDRACIN LOTION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Topical Analgesics..

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

Decision rationale: The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The injured worker has utilized Dendracin lotion since 05/2013, without any evidence of objective functional improvement. There is no frequency or quantity listed in the current request. Therefore, the request is not medically necessary.

RETROSPECTIVE ZOLPIDEM TARTRATE 10MG: 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), Chronic Pain Chapter, Insomnia Treatment.

Decision rationale: The Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. The injured worker has utilized Ambien 10 mg since 05/2013, without any evidence of objective functional improvement. There is also no frequency or quantity listed in the current request. Therefore, the request is not medically necessary.

ZOLPIDEM 10MG, #120: 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), Chronic Pain Chapter, Insomnia Treatment.

Decision rationale: The Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. The injured worker has utilized Ambien 10 mg since 05/2013, without any evidence of objective functional improvement. There is also no frequency or listed in the current request. Therefore, the request is not medically necessary.

RETROSPECTIVE USAGE OF PRIALT INJECTION (FOR COMPLEX REGIONAL PAIN SYNDROME): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Implantable Drug-Delive.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline Or Medical Evidence.

Decision rationale: The Prialt solution is an N-type calcium channel antagonist indicated for the management of severe chronic pain in patients for whom intrathecal therapy is warranted, and who are intolerant of or refractory to other treatments such as systemic analgesics, adjunctive therapy, or intrathecal morphine. The injured worker does not meet criteria for the requested medication. There is no evidence of a contraindication to other treatment options such as analgesics, adjunctive therapies, or intrathecal morphine. There is also no strength or quantity listed in the current request. As such, the request is not medically necessary.

USAGE OF PRIALT INJECTION (FOR COMPLEX REGIONAL PAIN SYNDROME): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Implantable Drug-Delive.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence.

Decision rationale: The Prialt solution is an N-type calcium channel antagonist indicated for the management of severe chronic pain in patients for whom intrathecal therapy is warranted, and who are intolerant of or refractory to other treatments such as systemic analgesics, adjunctive therapy, or intrathecal morphine. The injured worker does not meet criteria for the requested medication. There is no evidence of a contraindication to other treatment options such as analgesics, adjunctive therapies, or intrathecal morphine. There is also no strength or quantity listed in the current request. As such, the request is not medically necessary.