

Case Number:	CM14-0013846		
Date Assigned:	04/09/2014	Date of Injury:	05/14/1998
Decision Date:	05/28/2014	UR Denial Date:	01/21/2014
Priority:	Standard	Application Received:	02/03/2014

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 Orthopedic Surgery 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:

The patient is a 48-year-old female who sustained an injury to her right upper extremity on 6/28/1998. She was diagnosed as having complex regional pain syndrome (CRPS) type I. She continues to complain of severe debilitating pain in her right upper extremity. The patient has a right frozen shoulder which she cannot move in any plane. The hand and wrist are in ulnar deviation with a slight flexion contracture and the patient had a flexion contracture of the right elbow. The patient is unable to rotate her wrist and has hypersensitivity and allodynia around the entire right upper extremity. Electrodiagnostic studies of the right upper extremity revealed a mild to moderate right ulnar nerve entrapment at the elbow. The patient has a major depression and anxiety complex. The patient has been and continues to be on a directed and self-directed exercise program. She is to undergo a spinal cord stimulator trial to see if this can relieve some of the pain in her right upper extremity which is becoming steadily worse. There is a request for retroactive approval of medications that the patient is currently on. These include Hydrocodone/Acetaminophen 10/325 mg, Naprosyn 550 and Topiramate 100 mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR HYDROCODONE/APAP 10/325MG, #180 DOS:
12/5/13: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria For The Use Of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-93.

Decision rationale: According to MTUS Chronic Pain Medical Treatment Guidelines the ongoing management of chronic pain with opioids requires ongoing monitoring of what is described as the 4 A's. These include analgesic effect, activities of daily living, adverse side effects, and aberrant drug taking behaviors, periodic drug screening to uncover issues of abuse, addiction, or poor pain control. Continue review of overall situation with regard to non-opioid means of pain control. Based on the medical records provided for review the patient has had initial drug screening in anticipation of using that as a baseline for medications, but there is no documentation of the 4 A's listed above. Therefore, the retrospective request for Hydrocodone/APAP 10/325mg, #180 DOS: 12/5/13 is not medically necessary and appropriate.

RETROSPECTIVE REQUEST FOR NAPROXEN 550MG, #120 DOS: 12/5/13: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-Steroidal Anti-Inflammatory Drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Discussion, Pain Intervention And Treatments, Nonsteroidal Anti-Inflammatory Medica.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines recommends non-steroidal anti-inflammatory drug (NSAIDs) for short-term symptomatic relief of pain. NSAIDs are recommended primarily in the early or very late stages of complex regional pain syndrome (CRPS-1) but there are no trials that have shown effectiveness in CRPS 1. When prescribing various treatment protocols including medication, demonstration of functional improvement is necessary at various milestones in the functional restoration program in order to justify continue treatment. Additionally, reports of pain severity may not correlate well with functional impact. Based on the medical records provided for review there is no documentation of the functional improvement achieved by taken NSAIDs. The retrospective request for Topiramate 100 mg, #90 DOS: 12/5/13 is not medically necessary and appropriate.

RETROSPECTIVE REQUEST FOR TOPIRAMATE 100MG, #90 DOS: 12/5/13: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Intervention And Treatment, CRPS Page(s): 1-11; 36-38.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines state that the use of antidepressants and anticonvulsants and opioids in treating the stimulus-independent pain of complex regional pain syndrome (CRPS-1) has been primarily extrapolated based on use for other neuropathic pain disorders. Therefore, in order to continue using a medication for CRPS, it is necessary to demonstrate a functional improvement from the use of that medication. This

determines the effectiveness of this medication for this patient. Since all medications have side effects, this has to be weighed against the benefits that the patient achieves. While this medication may be beneficial for the patient benefit needs to be documented by demonstrating functional improvement. The above mentioned have not been provided in the medical records and therefore, cannot be supported. The retrospective request for Topiramate 100mg, #90 DOS: 12/5/13 is not medically necessary and appropriate.