

Case Number:	CM14-0017456		
Date Assigned:	04/14/2014	Date of Injury:	09/17/2008
Decision Date:	05/29/2014	UR Denial Date:	02/05/2014
Priority:	Standard	Application Received:	02/11/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine 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 is a 36 year old female with an injury date of 09/17/08. Based on the 11/08/13 progress report provided by [REDACTED] the patient's diagnosis include possible radial neuropathy of the right hand causing paresthesias and dysesthesias on the dorsum of the hand versus carpal tunnel syndrome versus chronic regional pain syndrome. The 11/08/13 progress report continues to state that the patient has daily pain at 7-8/10 of the right wrist. She also has daily numbness, spasms, and tightness in the right hand, which prevents her from engaging in regular activities. She does minimum chores, has issues falling asleep due to pain, and admits to feeling depressed sometimes due to chronic pain in the right hand that limits her level of activities.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRAMADOL 50MG, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80-84.

Decision rationale: The request is for Tramadol 50 mg #60. The patient was first prescribed Tramadol on 08/15/13. For chronic opiate use, MTUS Guidelines page 88 and 89 require functioning documentation using a numerical scale or validated instrument at least one every six months, documentation of the 4 A's (analgesia, ADLs, adverse side effects, adverse behavior) is required. Furthermore, under outcome measure, it also recommends documentation of chronic pain, average pain, least pain, the time it takes for medication to work, duration of pain relief with medication, etc. Subsequent reports do not provide any discussion regarding how tramadol has been helpful in terms of decreased pain or functional improvement. In addition, the treating physician does not use any numerical scales to assess patient's pain and function as required by MTUS. Given the lack of sufficient documentation demonstrating efficacy for chronic opiate use, the patient should slowly be weaned as outlined in MTUS Guidelines.

GABAPENTIN 600MG, # 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 18-19.

Decision rationale: The patient began taking gabapentin on 05/17/13. The treating physician does not provide any documentation as to how gabapentin is specifically tolerated and beneficial for the patient's symptoms. For gabapentin MTUS requires that the patient be asked at each visit as to whether there has been a change in pain or function. Combination therapy is only recommended if there is no change with first-line therapy, with the recommended change being at least 30%. In this case the patient has been prescribed gabapentin since 05/17/13 without specific documentation of improvement. None of the reports describe the drug's efficacy. MTUS requires documentation of pain and function with use of medications for chronic pain. Recommendation is for denial.

MIRTAZAPINE 15MG, #30: Upheld

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 Pain Chapter, Insomnia Treatments

Decision rationale: The MTUS and ACOEM guidelines do not discuss this medication. Therefore, ODG guidelines were referenced. ODG guidelines state that sedating antidepressants (e.g., amitriptyline, trazodone, mirtazapine) can be used to treat insomnia; however, there is less evidence to support their use (Buscemi, 2007) (Morin, 2007), but they may be an option in patients with coexisting depression. Per 11/08/13 progress report, the patient has problems falling asleep, wakes up in the middle of the night and has depression due to the chronic pain in her right hand which limits her activities. Given the reports discussion regarding depression and the patient's insomnia from chronic pain, use of this medication may be appropriate. However,

none of the reports document the patient's sleep disturbance. None of the reports discuss how this medication has helped with the patient's sleep issues and how it has changed the patient's daily function. MTUS page 60 require discussion of pain/function for medications used to treat chronic pain. Given the lack of any documentation regarding this medication's efficacy, recommendation is for denial.

DICLOFENAC 100MG, #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medication For Chronic Pain Page(s): 60-61.

Decision rationale: The MTUS guidelines support NSAIDs for neuropathic pain with mixed conditions. In this patient, the treating physician does not provided any documentation regarding medication efficacy. None of the reports state what this medication is doing for the patient's pain. MTUS page 60 require documentation of function and pain when medications are used for chronic pain. Given the lack of documentation of efficacy, recommendation is for denial.

FLEXERIL 7.5MG, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzprine, Flexeril Page(s): 64.

Decision rationale: The patient began taking Flexeril on 11/08/13. According to the MTUS guidelines, cyclobenzaprine is not recommended to be used for longer than 2-3 weeks. There is no indication of how frequently this patient will be taking Flexeril each day; therefore, it is not clear how long the patient will be taking this medication for. Recommendation is for denial.

PROTONIX 20MG, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation the ODG, Pantoprazole.

Decision rationale: The request is for Protonix 20 mg #60. MTUS supports the usage of Proton Pump Inhibitors (PPIs) for gastric side effects due to NSAID use. ODG also states that PPIs are recommended for patients at risk for gastrointestinal events. The treating physician has not documented any gastrointestinal symptoms for this patient. Routine use of PPI for prophylaxis is not supported without GI assessment. Recommendation is for denial.

