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| Case Number: | CM14-0113455 | | |
| Date Assigned: | 08/01/2014 | Date of Injury: | 10/15/2003 |
| Decision Date: | 09/23/2014 | UR Denial Date: | 07/09/2014 |
| Priority: | Standard | Application Received: | 07/21/2014 |

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 Family Practice, has a subspecialty in Preventative 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 48 year old female claimant sustained a work injury on 10/5/2003 involving the left shoulder. She was diagnosed with thoracic outlet syndrome and underwent shoulder decompression in April 2013. She developed left upper extremity chronic regional pain syndrome. A progress note on 6/19/14 indicated the claimant had 8/10 pain in the left shoulder. The claimant had limited painful range of motion. There was no mention of return to work or improved function. A progress note on 6/16/14 indicated the claimant had not reached maximum medical improvement and required further testing and surgical intervention for her shoulder. A progress note on 8/4/14 indicated the claimant had continued upper extremity pain and reduced range of motion. The treating physician requested cognitive behavioral therapy. The claimant had also been on Elavil 75 mg daily for improving sleep and Norco for pain control. The claimant had been on Norco since 2010 and Elavil since 2012.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription of Norco 10/325 Mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids
Page(s): 82-92.

Decision rationale: Norco is a short acting opioid used for breakthrough pain. According to the MTUS guidelines it is not indicated at 1st line therapy for neuropathic pain, and chronic back pain . It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant had been on Norco 4 years without noted improvement in pain or function. The continued use of Norco is not medically necessary.

1 Prescription of Elavil 75 Mg #45: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 15.

Decision rationale: Elavil is a tricyclic antidepressant. According to the MTUS guidelines, antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclic antidepressants have been shown in both a meta-analysis and a systematic review to be effective, and are considered a first-line treatment for neuropathic pain. It is not indicated for insomnia management. In this case, Elavil had been used for years. Recent request noted its use in aid for sleeping. Its effect on pain or depression were not outlined. The continued use of Elavil is not medically necessary.

1 Cognitive Behavioral Pain Management Program: 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 Multi-disciplinary Program.

Decision rationale: According to the MTUS guidelines, Criteria for the general use of multidisciplinary pain management /CBT programs are: (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed. In this case, there is no documentation of motivation to change, exhaustion of pain management options or plan to return to work. There is no clear indication of baseline functional testing to determine future functional improvement. There was also mention of possible need for

surgical intervention to attain maximum medical improvement. Based on the above, the request for CBT is not medically necessary.