MAXIMUS Federal Services

Case Number:	CM14-0115517		
Date Assigned:	08/04/2014	Date of Injury:	04/09/2004
Decision Date:	09/12/2014	UR Denial Date:	07/03/2014
Priority:	Standard	Application Received:	07/23/2014

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 and Rehabilitation and is licensed to practice in Texas and Oklahoma. 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 40-year-old female who reported an injury on 04/09/2004 due to an unknown mechanism. Diagnoses were left carpal tunnel syndrome, moderately severe by electrodiagnostic testing; history of right carpal tunnel decompression. Past treatments were not reported. Diagnostic studies was electrodiagnostic testing. Past surgery was right carpal tunnel decompression. The injured worker had a physical examination on 05/29/2014 with complaints of frequent tingling and numbness in the left hand with associated wrist pain. Examination revealed focal tenderness noted over the left carpal tunnel with little, if any, tenderness on the right side. No fixed sensory deficit was appreciated in either hand or upper extremity at the time. Tinel's sign was negative. Phalen's sign was positive on the left side. These tests were negative in the right upper extremity. Proximal provocative testing remains negative bilaterally. Medications were Voltaren 100 mg 1 tablet daily, Prilosec 20 mg 1 tablet twice a day, and Ultram ER 150 mg 1 to 2 tablets daily as needed. The rationale was not submitted. The request for authorization was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lyrica 100mg #90: 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 Specific Antidepressants, page(s) 16 Page(s): 16.

Decision rationale: The request for Lyrica 100 mg #90 is not medically necessary. The California Medical Treatment Utilization Schedule states Lyrica is an anticonvulsant that has been documented to be effective in treatment of diabetic neuropathy and postherpetic neuralgia; the FDA's approval for both are indicated and it is considered a first-line treatment for both. This medication is designated as a schedule V controlled substance because of its causal relationship with euphoria. This medication also has an antianxiety effect. Pregabalin is being considered by the FDA as treatment for generalized anxiety disorder and social anxiety disorder. Past conservative care modalities were not reported. Lyrica was not mentioned as one of the medications. The request submitted does not indicate a frequency for the medication. Therefore, the request is medically necessary.

Floricet #60 unknown quantity: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-Containing Analgesics (BCAs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management, page(s) 78 Page(s): 78.

Decision rationale: The request for Floricet #60 unknown quantity is medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that Floricet should be used for moderate to severe pain and there should be documentation of the "4 As" for ongoing monitoring including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behavior. This medication was not reported on the physical examination date 05/29/2014 that the injured worker was taking this medication. The request submitted does not indicate a frequency for the medication. The request is medically necessary.

Sertraline 100mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): 13.

Decision rationale: The request for sertraline 100 mg #30 is medically necessary. The California Medical Treatment Utilization Schedule states antidepressants for chronic pain are recommended as a first-line option for neuropathic pain, and as a possibility for nonneuropathic pain. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. It is recommended that these outcome measurements should be initiated at 1 week of treatment with a recommended trial of at least 4 weeks. This medication was not reported in the physical examination dated 05/29/2014. Also, the request

submitted does not indicate a frequency for the medication. Therefore, the request is medically necessary.