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| Case Number: | CM14-0124309 | | |
| Date Assigned: | 09/25/2014 | Date of Injury: | 01/24/2002 |
| Decision Date: | 12/11/2014 | UR Denial Date: | 07/29/2014 |
| Priority: | Standard | Application Received: | 08/06/2014 |

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 Anesthesiologist, 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 58-year-old male who reported an injury on 01/24/2002. The mechanism of injury was not reported. He was diagnosed with reflex sympathetic dystrophy of the left upper limb. Past treatments included medication, spinal cord stimulator therapy, and physical therapy. His surgical history included left thumb surgery in 06/2003 and spinal cord stimulator implantation on 03/29/2005. The Pain Management Re-Evaluation, dated 07/15/2014, indicated the injured worker presented for a followup and re-evaluation, noting no significant change from his previous visit on 06/17/2014. The injured worker complained of poor sleep quality due to pain, with his average pain level rated 8/10 since the prior visit, when it was noted that his pain level was also rated 8/10. Physical examination revealed hypersensitivity and allodynia to the left upper extremity and to the left thumb and index finger. His medications included Lyrica, methadone, MS Contin, Dilaudid, and Zanaflex. The treatment plan included continuing current medications and spinal cord stimulator therapy, a recommendation for occupational therapy, and continuing regular home exercises and physical therapy. Requests were submitted for Celebrex 200 mg #60, Zanaflex 4 mg #60, Subsys 400 mcg #30, and MS Contin 30 mg #60. However, the rationale for the requests and the Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Celebrex 200mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, Anti-inflammatory medications Page(s): 67-68, 22.

Decision rationale: The California MTUS Guidelines indicate anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long term use may not be warranted. COX 2 inhibitors, such as Celebrex, may be considered if the patient has a risk of gastrointestinal complications, but not for the majority of patients. The guidelines recommend non-steroidal anti-inflammatory drugs for the acute exacerbation of chronic pain as a second line treatment after acetaminophen. In addition, the lowest dose for the shortest period is recommended in patients with moderate to severe pain. Also, guidelines recommend providers weigh the indications for non-steroidal anti-inflammatory drugs against both gastrointestinal and cardiovascular risk factors. The pain management re-evaluation, dated 07/15/2014, indicated the injured worker complained of an average pain level rated at 8/10 since his last visit on 06/17/2014, where his pain was also 8/10. Per the documentation the injured worker has been prescribed anti-inflammatory medications since at least 2007. There was a lack of documentation which demonstrated the injured worker had significant gastrointestinal issues as he denied any gastrointestinal distress or new symptoms. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. Additionally, the request as submitted failed to indicate a frequency of use for the medication. Therefore, the request for Celebrex 200 mg #60 is not medically necessary.

Zanaflex 4mg #60: 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 muscle relaxants Page(s): 63.

Decision rationale: The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short term treatment of pain. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, it was noted that the medication was prescribed for sleep. The injured worker complained of poor sleep quality due to pain, with his average pain level rated as 8/10. The medical records submitted failed to provide sufficient documentation indicating the injured worker had significant objective functional improvement with the medication. There was a lack of documentation of significant muscle spasms. The injured worker has been prescribed Zanaflex since at least 06/17/2014; therefore, continued use of the medication would exceed the guideline recommendation for a short course of treatment. Additionally, the request as submitted failed to indicate a frequency of use for the medication. As such, the request for Zanaflex 4 mg #60 is not medically necessary.

Subsys 400 ugm #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Therapeutic Trial of Opioids Page(s): 76, 77. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain, Subsys[®] (fentanyl sublingual spray)

Decision rationale: The California MTUS Guidelines indicate a therapeutic trial of opioids should not be employed until the injured worker has tried and failed non-opioid analgesics. Baseline pain and functional assessment should be made. Function should include social, physical, psychosocial, daily and work activities, and should be performed with a validated instrument or numerical rating scale. The Official Disability Guidelines further state Subsys Fentanyl sublingual spray is not recommended for musculoskeletal pain. The FDA has approved Subsys Fentanyl sublingual spray only for breakthrough cancer pain. There was a lack of clinical documentation indicating what other therapies, such as non-opioid analgesics, were tried and failed. There was also a lack of documentation showing baseline pain and functional assessments for the injured worker. The requesting physician's rationale for the request is not indicated within the provided documentation. Additionally, the request as submitted failed to indicate a frequency of use for the medication. Due to the lack of clinical documentation to support the evidence based guidelines, the request for Subsys 400 ugm #30 is not medically necessary.

MS Contin 30 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): page 74-97.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, on-going management Page(s): 78.

Decision rationale: The California MTUS Guidelines recommend ongoing review of opioid use, including documentation of pain relief, functional status, appropriate medication use, and side effects. It should include current pain, intensity of pain before and after taking the opioid, how long it takes for pain relief, and how long the pain relief lasts. Satisfactory response to treatment may be indicated by decreased pain, increased level of function, or improved quality of life. The injured worker has been prescribed MS Contin since at least 02/25/2014. The clinical documentation submitted did not provide sufficient clinical evidence to support the guideline recommendations. There was a lack of documentation provided to indicate that the injured worker had functional improvement. The requesting physician did not provide documentation of an adequate and complete assessment of the injured worker's pain. Additionally, the request as submitted failed to indicate a frequency of use for the medication. The clinical documentation submitted failed to meet the evidence based guidelines for the ongoing management of opioid use. Therefore, the request for MS Contin 30 mg #60 is not medically necessary.