

Case Number:	CM14-0175232		
Date Assigned:	10/28/2014	Date of Injury:	11/21/1994
Decision Date:	12/04/2014	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/22/2014

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 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 injured worker is a 73-year-old female who reported an injury on 11/21/1994. The mechanism of injury was not submitted for review. The injured worker has a diagnosis of CRPS, reflex sympathetic dystrophy of upper extremity and neuralgia. Past medical treatments consist of nerve blocks, surgery, physical therapy and medication therapy. Medications include Lyrica, clonidine, Tegretol, Amitriptyline, Aspirin, Ketoprofen, Celebrex, and KGCL. No diagnostics were submitted for review. On 09/16/2014 the injured worker complained of right shoulder pain. It was noted on physical examination of the right shoulder that Neer's and 'Beer' were positive. Range of motion revealed a forward flexion of 90 degrees and an abduction of 90 degrees. It was also noted that the injured worker had right arm and shoulder atrophy. Medical treatment plan is for the continuation of medication therapy. The provider feels that the longer the injured worker goes without medication, the more difficult it will be to bring her back to her homeostatic norm. The Request for Authorization form was submitted on 01/30/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tegretol XR 100 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-17.

Decision rationale: The request for Tegretol is not medically necessary. The submitted documentation lacked the efficacy of the medication, nor did it indicate that the medication was helping with any functional deficits. The submitted documentation also lacked any indication of improvement in function, including increased ability to perform activities of daily living or decrease in work restrictions. It was documented that the injured worker was working with work restrictions. The guidelines recommend AED's as a first line therapy for neuropathic pain. A good response to an AED is considered as a 50% reduction in pain, while a moderate response is 30% reduction in pain. Guidelines also suggest that with lack of at least a moderate response it may warrant to switch to another first line agent or combination treatment. It was documented in the submitted report that the injured worker had been on the medication since at least 2012. Given the above, the injured worker is not within recommended guideline criteria. As such, the request is not medically necessary.

Celebrex 200 mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Celebrex Page(s): 30.

Decision rationale: The request for Celebrex 200 mg is not medically necessary. The provided documentation did not indicate the efficacy of the medication, nor did it indicate that it was helping with any functional deficits that the injured worker had. Celebrex is a non-steroidal anti-inflammatory drug, which is a Cox-2 inhibitor that does not interfere with aspirin's antiplatelet activity. Cox-2 inhibitors have a decreased risk for gastrointestinal events in at risk patients. NSAIDs are not recommended for a treatment of long term neuropathic pain. The submitted documentation indicates that the injured worker had been on Celebrex since at least 2012, exceeding the recommended guidelines for short term use. Additionally, there was no evidence of the injured worker being at increased risk for gastrointestinal event. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.

KGCL ointment 10/06/0.2 topical: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic Page(s): 111-113.

Decision rationale: The request for KGCL ointment is not medically necessary. The submitted documentation did not indicate the efficacy of the medication, nor did it indicate that it was

helping with any functional deficits the injured worker might have had. According to the MTUS Guidelines, topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety and are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Additionally, any compounded product that contains at least 1 drug that is not recommended is not recommended. It was documented in the submitted reports that the injured worker had been on the medication since at least 2012. There was no rationale submitted in this documentation to warrant the continuation of the medication. Additionally, the request as submitted did not indicate a dosage, frequency, or duration of the medication, nor did it indicate where the ointment would be applied. Given the above, the injured worker is not within MTUS recommended guidelines. As such, the request is not medically necessary.

Clonidine HCL 0.1 mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Catapres (Clonidine).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Clonidine, Intrathecal Page(s): 34-35.

Decision rationale: The request for clonidine HCl is not medically necessary. According to MTUS Guidelines, clonidine is a central acting alpha agonist indicated in the treatment of hypertension. Catapres is recommended for the treatment of pain only after a short term trial results in pain relief in patients refractory to opioid monotherapy or opioids with local anesthetic. There is little evidence suggesting long term pain relief. The submitted documentation lacked the efficacy of the medication, nor did it indicate that it was helping with the injured worker. Additionally, there were no diagnoses of the injured worker having hypertension. There was also no indication that the injured worker had a trial treatment of short term therapy with the medication. It was also noted in the submitted report that the injured worker had been on the medication since at least 2012. Without a rationale provided for review, the medical necessity of the continuation of the medication cannot be established. Given the above, the injured worker is not within recommended guideline criteria. As such, the request is not medically necessary.