

Case Number:	CM14-0186230		
Date Assigned:	11/14/2014	Date of Injury:	03/04/2011
Decision Date:	12/31/2014	UR Denial Date:	10/07/2014
Priority:	Standard	Application Received:	11/07/2014

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 Internal Medicine, and is licensed to practice in New York. 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 claimant is a 50 year old female who sustained an industrial injury on 03/04/2011. The mechanism of injury was not provided for review. Her diagnoses include reflex sympathetic dystrophy of the left upper extremity, left shoulder pain, cervical facet syndrome, depression, anxiety, and sleep disturbance related to pain, and s/p ulnar shortening of the left arm on 05/31/2011. She continues to complain of neck pain and bilateral hand pain. She has associated symptoms of joint stiffness, numbness, tingling, and weakness of the hands. On physical examination there is noted decreased in sensation to pin prick at the left C6, C7, C8 and T1, as well as allodynia and color changes. There is noted diffuse atrophy in the left forearm and hand. Treatment has consisted of medical therapy including narcotics, surgery, TENS unit, physical therapy, psychotherapy, and nerve blocks. The treating provider has requested Celebrex 200mg #60 x 2 refills, Celexa 20mg #60 x 2 refills, Norco 10/325mg #90 x 2 refills, Trazadone 50mg #60 x 2 refills, Gabapentin 800mg #60 x 1 refill, Lidocaine 5% patch #30 x 2 refills, and Pantoprazole 40mg # 30 x 2 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Celebrex 200mg #60 with 2 refills: Upheld

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

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

Decision rationale: NSAIDs may be grouped into three categories based on their relative selectivity for COX2; there are non-selective, partially selective, and selective agents. Celecoxib is a nonsteroidal anti-inflammatory drug (NSAID) that is a COX-2 selective inhibitor; a drug directly targets COX-2, an enzyme responsible for inflammation and pain. Celecoxib may have a lower risk of GI events relative to nonselective NSAIDs; however, this has not been conclusively demonstrated with long term use and it is not known how Celecoxib compares to generic partially selective NSAIDs. The difference in the absolute risk of serious GI effects between Celecoxib and other NSAIDs is small and of unknown clinical significance. Elderly, those using high doses of NSAID, concurrent use of corticosteroids or anticoagulants, and prior history of significant GI related events may result in an increase in the incidence of adverse effects from any NSAID. There is no specific indication for Celebrex therapy and there is no documentation that this particular medication has improved her functional ability. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

Celexa 20mg #30 with 2 refills: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Procedure Summary, Selective Serotonin Reuptake Inhibitors

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

Decision rationale: The requested medication, Celexa 20mg is medically necessary for the treatment of the patient's condition. The claimant has depression as part of his chronic pain condition. Celexa is an antidepressant in the group of drugs called selective reuptake inhibitors (SSRIs). The medical documentation indicates she is stable on the medication. Medical necessity for the medication has been established. The treatment is medically necessary.

Norco 10/325mg #90 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91-97.

Decision rationale: The documentation indicates the enrollee has been treated with opioid therapy with Norco for pain control. Per California MTUS Guidelines, short-acting opioids such as Norco are seen as an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last

assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. Per the medical documentation there has been no documentation of the medication's pain relief effectiveness and no clear documentation that she has responded to ongoing opioid therapy. According to the California MTUS Guidelines there has to be certain criteria followed including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred with this patient. The patient has continued pain despite the use of short acting opioid medications. Medical necessity for Norco 10/325 has not been established. The requested treatment is not medically necessary.

Trazodone 50mg #60 with 2 refills: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Procedure Summary

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

Decision rationale: There is documentation provided indicating the patient has sleep issues related to the work injury. She also is undergoing treatment for depression related to her chronic pain condition. Trazadone is indicated for the treatment of sleep disorders including insomnia and depression. The medication has anxiolytic and sleep-inducing effects. Given the effectiveness of the medication, medical necessity has been established. The requested treatment is medically necessary.

Gabapentin 800mg #60 with 1 refill: Overturned

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 Page(s): 13.

Decision rationale: The recommended medication, Gabapentin is medically necessary for the treatment of the patient's condition. Per the documentation she has neuropathic pain on the basis of the diagnosis of complex regional pain syndrome. The medication is part of her medical regimen and per California MTUS Guidelines 2009 antiepilepsy medications are a first line treatment for neuropathic pain. A recommended trial period for an adequate trial of gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. The patient has been prescribed the medication and the medical record documents a positive response. The patient's dose has been weaned to the present requested dose. Medical necessity has been documented and the requested treatment is medically necessary for treatment of the patient's chronic pain condition.

Lidocaine 5% patch (700mg/patch) #30 with 2 refills: Upheld

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

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

Decision rationale: There is no documentation provided necessitating use of the requested topical medication. Per California MTUS Guidelines topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, alpha-adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, γ agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor) Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case there is no documentation provided necessitating the use of Lidocaine patches. Per California MTUS 2009 Guidelines Lidoderm is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI antidepressants or an anticonvulsant medication such as gabapentin or Lyrica). The medication is only FDA approved for post-herpetic neuralgia. There is no documentation of intolerance to other previous treatments. Medical necessity for the requested topical medications has not been established. The requested treatments are not medically necessary.

Pantoprazole Sod Dr 40mg #30 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: Per California MTUS 2009 proton pump inhibitors are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. There is no documentation indicating the patient has any symptoms or GI risk factors. GI risk factors include: age >65, history of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants or high dose/multiple NSAID. The claimant has no documented GI issues. Based on the available information provided for review, the medical necessity for Pantoprazole has not been established. The requested medication is not medically necessary.