MAXIMUS Federal Services

Case Number:	CM14-0022793		
Date Assigned:	06/11/2014	Date of Injury:	02/02/2009
Decision Date:	07/15/2014	UR Denial Date:	02/19/2014
Priority:	Standard	Application Received:	02/24/2014

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, has a subspecialty in Pain Management 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:

This is a male patient with the date of injury of February 2, 2009. An Initial Consultation dated January 13, 2014 identifies Chief Complaints of constant pain in the right wrist shooting into right forearm with tingling and numbness. He scores his pain 7/10 on VAS. Physical Examination identifies ROM of right wrist is restricted. Right-sided de Quervain tenosynovitis is positive. Localized tenderness is present at right anatomical snuffbox. There is diminished sensation to light touch along the medial border of right forearm. Right-sided Tinel's sign is positive. Phalen's sign is strongly positive. Right handgrip strength is 4+/5. Allodynia and hyperalgesia is present on right wrist. Diagnoses identify status post right carpal tunnel release and de Quervain's tenolysis, right distal radius fracture, CRPS type I, and chronic myofascial pain syndrome. Discussion/Plan identifies start Naproxen and Neurontin.

IMR ISSUES, DECISIONS AND RATIONALES

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

NEURONTIN 600 MG: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009), Gabapentin Page(s): 16-21.

Decision rationale: Regarding request for Neurontin, Chronic Pain Medical Treatment Guidelines state that antiepilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is documentation of neuropathic pain and the patient is being started on Neurontin. As such, the currently requested Neurontin is medically necessary.

AMBIEN 10 MG: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Sleep Medication Section.

Decision rationale: Regarding the request for Ambien, California MTUS guidelines are silent regarding the use of sedative hypnotic agents. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there are no subjective complaints of insomnia, no discussion regarding how frequently the insomnia complaints occur or how long they have been occurring, and no statement indicating what behavioral treatments have been attempted for the condition of insomnia. Finally, there is no indication that Ambien is being used for short term use as recommended by guidelines. In the absence of such documentation, the currently requested Ambien is not medically necessary.

NAPROXEN 550 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009), NSAID Page(s): 67-72.

Decision rationale: Regarding the request for Naproxen, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is documentation of moderate to severe pain. However, there is no documentation that Naproxen is to be given at the lowest dose for the shortest period of time. Additionally, there is no documentation of specific analgesic benefit or objective functional improvements. In the absence of such documentation, the currently requested Naproxen is not medically necessary.