

Case Number:	CM14-0054027		
Date Assigned:	07/07/2014	Date of Injury:	07/22/2012
Decision Date:	08/28/2014	UR Denial Date:	04/08/2014
Priority:	Standard	Application Received:	04/23/2014

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 Occupational Medicine and is licensed to practice in Hawaii and 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 case is a 54 year old female with a date of injury 7/22/2012. A review of the medical documents indicate that the patient was undergoing treatment for CRPS, ulnar nerve entrapment, cervicgia, depressive disorder, and anxiety state. Subjective complaints (6/30/2014) include bilateral upper extremity pain. Objective findings (6/15/2014) include mildly sedated, good historian, slight muscle wasting of the right forearm, and allodynia throughout right forearm. Treatment has included indomethacin, Neurontin, Temazepam, physical therapy (unknown number of sessions), occupational therapy (unknown number of sessions), right stellate ganglion block (x5), cymbalta, ibuprofen, Provigil, Lidoderm patch, norco 5/325, amitriptyline, fluoxetine, diazepam, and elbow replacement (7/27/2012). A utilization review dated 4/8/2014 made the following determination: not medically necessary a request for 1 Revision of the right elbow replacement due to not being a surgical candidate. modified a request for Lidoderm 5% #90 with 2 refills to Lidoderm 5% #60 with 2 refills due to excessive quantity that is necessary from medical documents. Modified a request Norco 10/325mg #120 with 2 refills to Norco 10/325mg #54 with no refills for the purpose of weaning. A Modified a request for Temazepam 30mg #30 with 2 refills to Temazepam 30mg #25 with no refills for the purpose of weaning.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Revision of the right elbow replacement: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 34-5.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 34-39. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow (acute and chronic), Total elbow replacement (TER).

Decision rationale: ACOEM states regarding surgical considerations for elbow complaints, "The timing of a referral for surgery should be consistent with the condition that has been diagnosed, the degree of functional impairment, and the progression and severity of objective findings. Conditions that produce objective evidence of nerve entrapment and that do not respond to non-surgical treatment can be considered for surgery when treatment failure has been documented, in spite of compliance with treatment. Conditions of inflammatory nature may take many months to heal and the timing of a surgical consultation referral should take into consideration the normal healing time. Referral for surgical consultation may be indicated for patients who have:- Significant limitations of activity for more than 3 months;-Failed to improve with exercise programs to increase range of motion and strength of the musculature around the elbow; or-Clear clinical and electrophysiologic or imaging evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair."ODG further specifies, "Recommended for the treatment of an acute distal humeral fracture, when strict inclusion criteria are observed. (Muller, 2005) (Landor, 2006) (Krishnan, 2007).Indications for surgery -- Total elbow replacement (TER):-Non-soft-tissue-attached fragments, poor-quality bone, where stable osteosynthesis is not attainable. Severely comminuted intraarticular closed type C fractures according to the AO classification with multiple small bone/cartilage fragments. In case of degenerative joint diseases and/or previous surgery in rheumatoid patients also type A and B fractures. High compliance, low demand, and old patient > 65 years. Contraindications: Type II or III Gustilo-Anderson open fractures (primary irrigation and debridement). Preexisting infection, open wounds. Younger, high-demand or noncompliant patient. Paralysis of the biceps muscle."The medical records provided do not support inclusion criteria noted above. The treating physician does not outline his rationale for requesting a revision of the elbow. As such, 1 Revision of the right elbow replacement is not medically necessary at this time.

1 Prescription of Lidoderm 5% #90 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines (May 2009); Topical Medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm patches Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Topical analgesics. Other Medical Treatment Guideline or Medical Evidence: UpToDate.com, Lidocaine (topical).

Decision rationale: Chronic Pain Medical Treatment Guidelines state "Lidoderm is the brand name for a lidocaine patch produced by Endo Pharmaceuticals. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not

a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. For more information and references, see Topical analgesics." ODG further details, "Criteria for use of Lidoderm patches:(a) Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology.(b) There should be evidence of a trial of first-line neuropathy medications (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica).(c) This medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points.(d) An attempt to determine a neuropathic component of pain should be made if the plan is to apply this medication to areas of pain that are generally secondary to non-neuropathic mechanisms (such as the knee or isolated axial low back pain). One recognized method of testing is the use of the Neuropathic Pain Scale.(e) The area for treatment should be designated as well as number of planned patches and duration for use (number of hours per day).(f) A Trial of patch treatment is recommended for a short-term period (no more than four weeks).(g) It is generally recommended that no other medication changes be made during the trial period.(h) Outcomes should be reported at the end of the trial including improvements in pain and function, and decrease in the use of other medications. If improvements cannot be determined, the medication should be discontinued.(i) Continued outcomes should be intermittently measured and if improvement does not continue, lidocaine patches should be discontinued."Medical documents provided do not indicate that the use would be for post-herpetic neuralgia. There are reported side effects from Lyrica, but gabapentin is still actively being used and medical records do not indicate that gabapentin has failed. In the prescription for Lidoderm, the treating physician does not identify the area that the patches would be used for other than "4 patches apply to skin for 12 hours q day #120". As such, the request for Lidoderm 5% #90 with 2 refills is not medically necessary.

1 Prescription of Norco 10/325mg #120 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute and Chronic), Opioids, Pain.

Decision rationale: ODG does not recommend the use of opioids except for short use for severe cases, not to exceed 2 weeks. The patient has exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. The original utilization review approved for norco with modification for the purposes of weaning, which was appropriate. As such, the request for 1 Prescription of Norco 10/325mg #120 with 2 refill is not medically necessary.

1 Prescription of Temazepam 30mg #30 with 2 refills: 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) Pain (Chronic) Benzodiazepines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepine Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Temazepam. Other Medical Treatment Guideline or Medical Evidence: Temazepam (Restoril) package insert.

Decision rationale: Temazepam is a benzodiazepine. MTUS states regarding benzodiazepine, Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. ODG also notes Not recommended and Criteria for use if provider & payer agree to prescribe anyway: 1) Indications for use should be provided at the time of initial prescription and 2) Authorization after a one-month period should include the specific necessity for ongoing use as well as documentation of efficacy. Medical records indicate that the patient has been on benzodiazepines far in excess of 4 weeks. Additionally, the request for three total months of benzodiazepine with no interim evaluation is not recommended. The original utilization review modified the request for purposes of weaning, which was appropriate. As such, the request for 1 Prescription of Temazepam 30mg #30 with 2 refills is not medically necessary.