

Case Number:	CM14-0078487		
Date Assigned:	07/18/2014	Date of Injury:	02/26/1990
Decision Date:	09/15/2014	UR Denial Date:	05/20/2014
Priority:	Standard	Application Received:	05/28/2014

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 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 female with date of injury 2/26/1990. Per primary treating physician's progress report dated 5/8/2014, the injured worker presents for pain management follow up. She reports no change with her right hand. She has been using finger splints for the right hand to help relieve the symptoms and maintain the function, although very minimal. She describes her pain as constant but flares up intermittently. The pain is described as aching, sharp shooting, stabbing, throbbing, and tender. The pain radiates to the right upper extremity. She says on average the pain is 5/10, and is made worse by increased activity and lifting. Her pain gets better by taking medications and resting. On examination she is in no acute distress. Her right hand is presented with typical RSD changes with edema and color, plus mild finger contracture. There is allodynia to light touch. Diagnoses include 1) right wrist injury status post five surgeries 2) complex regional pain syndrome, right upper extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Celebrex 200mg #30 QTY: 30.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drugs (NSAIDs) Page(s): 67-68, 70.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-71.

Decision rationale: The use of NSAIDs are recommended by the MTUS Guidelines with precautions. NSAIDs are recommended to be used secondary to acetaminophen, and at the lowest dose possible for the shortest period in the treatment of acute pain, or acute exacerbation of chronic pain as there are risks associated with NSAIDs and the use of NSAIDs may inhibit the healing process. The injured worker sustained her injury over 24 years ago, and has been on Celebrex without any apparent benefit. Her pain and function remain unchanged. The request for Celebrex 200mg #30 QTY: 30.00 is determined to not be medically necessary.

Restoril 30mg #30 QTY: 30.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepine Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Section and Weaning of Medications Page(s): 24, 124.

Decision rationale: The MTUS Guidelines do not recommend the use of benzodiazepines for long-term use. The reasoning is, because long-term efficacy is unproven and there is a risk of dependence, and long-term use may actually increase anxiety. The injured worker has already been on this medication for over 4 weeks, and tapering is required when used for greater than 2 weeks. The request for Restoril 30mg #30 QTY: 30.00 determined to not be medically necessary.

Stadol NS 10mg/ml QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Weaning of Medications Page(s): 74-75, 78-80, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Weaning of Medications, page(s) Opioids, Weaning of Medications Page(s): 74-95, 124.

Decision rationale: Stadol NS is a synthetically derived opioid agonist-antagonist analgesic that is delivered by nasal spray. The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. They do provide guidance on the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Continued opioid pain medications may be used if functional improvement is documented or the patient is able to return to work as a result of opioid pain management. Per the MTUS Guidelines, Stadol has limited use among chronic pain patients because of its ceiling effect for analgesia. The results in the analgesic effect, are not increasing with dose escalation. The medical documents provided for review do not provide information to establish medical necessity. It is not advisable to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to maintain treatment. The request for Stadol NS 10mg/ml QTY: 1.00 is determined to not be medically necessary.