

Case Number:	CM14-0087594		
Date Assigned:	07/23/2014	Date of Injury:	11/01/2005
Decision Date:	09/16/2014	UR Denial Date:	06/05/2014
Priority:	Standard	Application Received:	06/11/2014

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 Interventional Spine 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 62 year old male with an injury date on 11/05/2005. Based on the 05/09/2014 progress report provided by [REDACTED], the diagnoses are: RSD/CRPS, CMC arthropathy, and depression with question with relationship to upper extremities. According to this report, the patient complains of pain in the hands. The pain is described as aching, burning and stabbing in both hands. The pain is rated as an 8/10 today without medications. Without medication, the patient only walks and stands, can't cook a meal or shop for more than a few items. The patient has had "extensive physical therapy but without significant benefit." The patient's current medications are Exalgo, Hydrocodone, Norco, Diphenhydramine, Lyrica, Lunesta, and Tizanidine. There were no other significant findings noted on this report. The utilization review denied the request on 06/05/2014. [REDACTED] is the requesting provider, and he provided treatment reports from 10/29/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

Clonidine 0.1mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Drugs.com.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Recommended only as indicated below. Most medications have limited effectiveness, and recommendations are primarily based on extrapolation from neuropathic pain medication guidelines. A reason given for the paucity of medication studies is the absence of a gold-standard diagnostic test for CRPS and lack of uniformly accepted diagnostic criteria. (Ribbers, 2003) (Quisel2, 2005) (Harden, 2013) 1. Regional inflammatory reaction: Commonly used drugs are NSAIDs, corticosteroids and free-radical scavengers. There is some evidence of efficacy for topical DMSO cream, IV bisphosphonates and limited courses of oral corticosteroids. Corticosteroids are most effective earlier in the condition when positive response is obtained with sympathetic blocks. NSAIDs are recommended but no trials have shown effectiveness in CRPS-I, and they are recommended primarily in early or very late stages. (Stanton-Hicks, 2004) (Sharma, 2006) Because long-term controlled studies have not been conducted, DMSO should be considered investigational and used only after other therapies have failed. (FDA, 2010) 2. Stimulus-independent pain: The use of antidepressants (primarily tricyclics and SNRIs), anticonvulsants (with the most support for gabapentin), and opioids has been primarily extrapolated based on use for other neuropathic pain disorders. There are no long term studies demonstrating efficacy of opioids as treatment for CRPS. Opioids are a second- to third- line choice for patients failing other pharmacologic interventions with the understanding that long-term use can actually worsen allodynia and/or hyperalgesia. See Antidepressants for neuropathic pain; Anticonvulsants for chronic pain; & Opioids for neuropathic pain. Current literature does not support the use of clonidine. (Hsu, 2009) (Harden, 2013) 3. Stimulus-evoked pain: treatment is aimed at central sensitization. With NMDA receptor antagonists (ketamine and amantadine) convincing controlled trials are lacking, and these drugs are recognized for their side effects. See Ketamine. 4. Sympathetically maintained pain (SMP): See IV regional sympathetic blocks (for RSD/CRPS); CRPS, sympathetic block (therapeutic); CRPS, treatment. 5. Treatment of bone resorption and resultant pain with bisphosphonate-type compounds and calcitonin. Bisphosphonates include alendronate, ibandronate, risedronate, zoledronate, etidronate, and pamidronate. There is no research on the newer longer-lasting drugs that are administered by periodic IV infusion (ibandronate, zoledronate and pamidronate). Significant improvement has been found in limited studies with intravenous alendronate. Alendronate (Fosamax ®) given in oral doses of 40 mg a day (over an 8 week period) produced improvements in pain, pressure tolerance and joint mobility. There has also been evidence of improvement of pain with pamidronate. Osteopenia was not an outcome. (Manicourt, 2004) Mixed results have been found with intranasal calcitonin (Miacalcin ®). (Sahin, 2005) (Appelboom, 2002) (Rowbathan, 2006) (Sharma, 2006) (Perez, 2001) The mechanism of action of these drugs is uncertain. 6. Treatment of dystonia: Oral baclofen is a first-line option. Benzodiazepines and long-term use of muscle relaxants such as cyclobenzaprine are not recommended. (Harden, 2013) 7. Treatment considered experimental and not recommended: IVIG, Sildenafil.

Decision rationale: According to the 05/09/2014 report by [REDACTED] this patient presents with pain in the hands and the patient has a diagnosis of CRPS. The physician is requesting to start Clonidine 0.1mg #60. The utilization review denied the request citing lack of medical necessity. Regarding clonidine for CRPS, ODG states "Current literature does not support the use of clonidine." MTUS does not discuss oral Clonidine for pain, only discussing intrathecal clonidine use. Therefore, the request for the medication is not medically necessary.