

Case Number:	CM14-0218701		
Date Assigned:	02/10/2015	Date of Injury:	07/29/2002
Decision Date:	05/20/2015	UR Denial Date:	12/04/2014
Priority:	Standard	Application Received:	12/30/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 female, who sustained an industrial injury on 07/29/2002. The diagnoses have included right upper extremity complex regional pain syndrome, left upper extremity overuse syndrome, right upper extremity pain, right wrist pain, depression secondary to chronic pain gastrointestinal dyspepsia secondary to chronic use of opiates and dental degeneration secondary to chronic use of opiates. Treatment to date has included medications, cervical epidural steroid injections, stellate ganglion blocks, physical therapy, and an implanted spinal cord stimulator. The injured worker presented on 11/12/2014 for a follow-up evaluation with complaints of worsened pain since running out of medications two weeks prior. The patient reported constant aching, burning pain in the right arm, rated as 8-9/10. The patient indicated that the medications allow her to function with activities of daily living. Upon examination, cervical spine range of motion was normal in all directions. The right upper extremity was noticeably swollen and discolored in the area of the wrist, hand, fingers and distal forearm. Significant swelling in the fingers of the right hand is noted. The right hand was in a clawed position and the injured worker had difficulty making a fist. There was positive allodynia and positive hyperalgesia. Recommendations included a continuation of the current medication regimen and continuation of IV Lidocaine therapy on an as needed basis. A Request for Authorization Form for was submitted on 11/25/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ibuprofen 800mg #30 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second line option after acetaminophen. In this case, there is no documentation of acute exacerbation of chronic pain. The injured worker does not maintain a diagnosis of osteoarthritis. The medical necessity for the ongoing use of ibuprofen 800 mg has not been established. It is noted, that the injured worker has continuously utilized the above medication since at least 07/2014 there was no mention of objective functional improvement following the ongoing use of this medication. The request for ibuprofen 800 mg with 2 refills would not be supported, as the California MTUS Guidelines do not recommend long term use of NSAIDs. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

Keppra 500mg #30 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

Decision rationale: California MTUS Guidelines state Keppra is FDA approved for neuropathic pain; however, the ultimate role of Keppra for pain requires further research and experience. In the interim, Keppra should be used to treat neuropathic pain only when carbamazepine, gabapentin, or lamotrigine cannot be used. In this case, there was no evidence of a failure of first line treatment prior to the initiation of Keppra. The injured worker has continuously utilized the above medication since at least 07/2014. There is no documentation of objective functional improvement. There is also no frequency listed in the request. Given the above, the request is not medically necessary at this time.

Tizanidine 4mg #60 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as nonsedating second line options for short term treatment of acute exacerbations. Efficacy appears to diminish over time and prolonged use may lead to dependence. In this case, there was no evidence of palpable muscle spasm or spasticity upon examination. The medical necessity for the requested medication has not been established. It is also noted, that the injured worker has utilized the above medication since 07/2014. California MTUS Guidelines do not support long term use of muscle relaxants. There is also no frequency listed in the request. As such, the request is not medically necessary.

Norco 10/325mg #120 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): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects should occur. In this case, it is noted that the injured worker has continuously utilized the above medication since at least 07/2014. Recent urine toxicology reports documenting evidence of the injured worker compliance and nonaberrant behavior were not provided for review. There is no documentation of objective functional improvement despite the ongoing use of this medication. In addition, there is no frequency listed in the request. As such, the request is not medically necessary at this time.

Celebrex 200mg #60 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: California MTUS Guidelines state Celebrex is indicated for the relief of signs and symptoms of osteoarthritis, rheumatoid arthritis and ankylosing spondylitis. The injured worker does not maintain any of the mentioned diagnoses. In addition, the injured worker has continuously utilized Celebrex 400 mg along with ibuprofen 800 mg since at least 07/2014. There is no documentation of objective functional improvement. The medical necessity for the use of 2 separate NSAIDs has not been established. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

Unknown IV lidocaine therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Colorado Division of Workers' Compensation. Complex regional pain syndrome/reflex sympathetic dystrophy, medical treatment guidelines. Denver (CO).

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

Decision rationale: California MTUS Guidelines state lidocaine is indicated for neuropathic pain or localized peripheral pain after there has been evidence of a trial of first line therapy with tricyclic and SNRI antidepressants or and anticonvulsants. Topical lidocaine in the formulation of dermal patch has been FDA approved for neuropathic pain. No other commercially approved topical formulation of lidocaine is indicated. The request as submitted for unknown IV lidocaine therapy is not medically appropriate. It is noted the injured worker has been previously treated with IV lidocaine therapy since 07/2014. There is no documentation of objective functional improvement following the initial treatment session. The medical necessity has not been established in this case. Therefore, the request is not medically necessary.

1 urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43, 77, 89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Urine Drug testing.

Decision rationale: California MTUS Guidelines state drug testing is recommended as an option, using a urine drug screen to assess for the use or presence of illegal drugs. The Official Disability Guidelines state the frequency of urine drug testing should be based on documented evidence of risk stratification. Patients at low risk of addiction or aberrant behaviors should be tested within 6 months of initiation of therapy and on a yearly basis thereafter. As per the clinical notes submitted, there is no mention of non-compliance or misuse of medication. There is no indication that this injured worker falls under a high risk category that would require frequent monitoring. Therefore, the current request is not medically necessary.

Cimetidine 400mg #60 with 2 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Katz PO, Gerson LB, Vela MF. Guidelines for the diagnosis and management of gastroesophageal reflux disease. Management of GERD.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 69.

Decision rationale: California MTUS Guidelines state, for treatment of dyspepsia secondary to NSAID therapy, the provider should discontinue the NSAID, switch to a different NSAID, or consider an H2-receptor antagonists or a PPI. In this case, there was no documentation of dyspepsia secondary to NSAID therapy. The ongoing use of therapy prescribed NSAIDs has not been authorized at this time; therefore, the medical necessity for the ongoing use of the above medication has not been established. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

Colace 250mg #60 with 2 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation McKay SL, Favel M, Scanlon C. Management of constipation. Iowa City, (IA), University of Iowa Gerontological Nursing Interventions Research Center, Research Translation and Dissemination Core, 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 70. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Opioid induced constipation treatment.

Decision rationale: The California MTUS Guidelines recommend prophylactic treatment of constipation when also initiating opioid therapy. The Official Disability Guidelines recommend first line treatment for opioid induced constipation to include increasing physical activity, maintaining appropriate hydration and advising the patient follow a proper diet. In this case, there is no evidence of chronic constipation secondary to medication use. There is also no evidence of a failure of first line treatment as recommended by the above mentioned guidelines. There is no frequency listed in the request. Given the above, the request is not medically necessary.