

Case Number:	CM15-0108887		
Date Assigned:	06/15/2015	Date of Injury:	02/16/2006
Decision Date:	07/14/2015	UR Denial Date:	05/20/2015
Priority:	Standard	Application Received:	06/05/2015

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: North Carolina
 Certification(s)/Specialty: Family Practice

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 58 year old male with an industrial injury dated 02/16/2006. The mechanism of injury is documented as lifting resulting in pain in left wrist. His diagnoses was complex regional pain disorder; upper extremity. Prior treatment included surgery, physical therapy and medications. He presents on 05/07/2015 with complaints of left upper extremity pain rated as 7/10 with medications and 9/10 without medication. The left wrist was fused with no range of motion. There was tenderness along the ulnar border of the left wrist, forearm and center of the palm. He experienced pain when touching his left thumb to the palm and there was tingling to touch when posterolateral left forearm was palpated. Range of motion of left shoulder was painful. Current medications were Elavil, Gabapentin and Hydrocodone. The provider documents the injured worker benefits mostly from the combination of Hydrocodone/APAP to address his neuropathic arm pain, Elavil for his neuropathic pain and activities of daily living and sleep and the Gabapentin for his neuropathic arm pain. Treatment plan included continuing Hydrocodone/APAP, Gabapentin and Elavil. Other treatment plan included four serum drug tests per year, toxicological testing and return visit. The provider documents the injured worker has an agreement regarding opioid therapy along with monitoring with the utilization of CURES and appropriate testing. The treatment request is for Gabapentin 100 mg # 180 (authorized), Hydrocodone/APAP 10/325 mg # 120 (authorized), 4 serum drug tests and Elavil 25 mg # 30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Elavil 25 mg #30: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines antidepressants Page(s): 11.

Decision rationale: The California MTUS section on antidepressants states: Specific Antidepressants: Tricyclic antidepressants are recommended over selective serotonin reuptake inhibitors (SSRIs), unless adverse reactions are a problem. Caution is required because tricyclics have a low threshold for toxicity, and tricyclic antidepressant overdose is a significant cause of fatal drug poisoning due to their cardiovascular and neurological effects. Tricyclic antidepressants have been shown in both a meta-analysis (McQuay, 1996) and a systematic review (Collins, 2000) to be effective, and are considered a first-line treatment for neuropathic pain. (Namaka, 2004) (Dworkin, 2003) (Gilron, 2006) (Wolfe, 2004) (Dworkin, 2007) (Saarto-Cochrane, 2007) This class of medications works in both patients with normal mood and patients with depressed mood when used in treatment for neuropathic pain. (Sindrup, 2005) Indications in controlled trials have shown effectiveness in treating central post-stroke pain, post-herpetic neuralgia (Argoff, 2004), painful diabetic and non-diabetic polyneuropathy, and post-mastectomy pain. Negative results were found for spinal cord pain and phantom-limb pain, but this may have been due to study design. (Finnerup, 2005) Tricyclics have not demonstrated significance in randomized-control trials in treating HIV neuropathy, spinal cord injury, cisplatin neuropathy, neuropathic cancer pain, phantom limb pain or chronic lumbar root pain. (Dworkin, 2007) One review reported the NNT for at least moderate neuropathic pain relief with tricyclics is 3.6 (3-4.5), with the NNT for amitriptyline being 3.1 (2.5-4.2). The NNT for venlafaxine, calculated using 3 studies, was reported to be 3.1 (2.2-5.1). (Saarto-Cochrane, 2007) Another review reported that the NNT for 50% improvement in neuropathic pain was 2 to 3 for tricyclic antidepressants, 4 for venlafaxine, and 7 for SSRIs (Perrot, 2008). The patient has neuropathic pain in the form of CRPS and therefore the request is medically necessary.

4 Serum drug tests: 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), National Guideline Clearinghouse.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 76-84.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: 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. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to nonopioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. The California MTUS does recommend drug screens as part of the criteria for ongoing use of opioids. The patient was on opioids at the time of request however the request is for 4 serum drug tests. As the future use of opioids and aberrant behavior cannot be determined, the request is not medically necessary.