

Case Number:	CM15-0133180		
Date Assigned:	07/21/2015	Date of Injury:	09/28/2009
Decision Date:	08/25/2015	UR Denial Date:	06/05/2015
Priority:	Standard	Application Received:	07/09/2015

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: New York

Certification(s)/Specialty: Pediatrics, Internal Medicine

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 46 year old female injured worker suffered an industrial injury on 9/28/2009. The diagnoses included chronic regional pain syndrome of the left upper extremity, insomnia, cervical degenerative disc disease, depression and bilateral carpal tunnel syndrome. The diagnostics included cervical and right shoulder magnetic resonance imaging. The treatment included medications, physical therapy, occupational therapy spinal cord stimulator, and nerve block. On 5/5/2015 the treating provider reported reduced cervical range of motion. There was pronounced allodynia over the left hand. She cannot extend fully the left hand fingers. The hand was cold with decreased muscle strength. There are color and temperature changes of the left hand. She had difficulty sleeping due to pain. The injured worker had not returned to work. The requested treatments included Dilaudid 4mg #150, Restoril 15mg #30, Zanaflex 4mg #90 and Lidoderm 5% patches #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Dilaudid 4mg #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Page(s): 74-96.

Decision rationale: MTUS discourages long term usage unless there is evidence of "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 documentation needs to contain assessments of analgesia, activities of daily living, adverse effects and aberrant drug taking behavior. "Functional improvement" is evidenced by a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management and a reduction in the dependency on continued medical treatment. The documentation provided did not include any evidence of functional improvement, comprehensive pain assessment and evaluation and no evidence of aberrant drug use assessment. Therefore Dilaudid was not medically necessary.

Restoril 15mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepine Page(s): 74.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines for Benzodiazepines does not recommend them for long term use because long term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/ hypnotic, anxiolytic, and anticonvulsant and muscle relaxant. CA MTUS Guideline indicates "Functional improvement" is evidenced by a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management and a reduction in the dependency on continued medical treatment. The documentation provided indicated the injured worker had sleep difficulty. The medical record did not include an evaluation and assessment of efficacy with this medication. The medication had been used for several months which exceeded the recommendation for short term use. Therefore Restoril was not medically necessary.

Zanaflex 4mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-65.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines recommended oral muscle relaxants for a short course 2 to 3 weeks for acute neck and back conditions or for acute exacerbations and any repeated use should be contingent on evidence of specific prior benefit. Efficacy diminished overtime and prolonged use may lead to dependence. The preference is for non-sedating muscle relaxants. There are also indications for post-operative use. The documentation provided indicated this medication had been used for at least several months without evidence of muscle spasms, no acute conditions or acute exacerbation which were specific indications for use. There was no evidence of prior benefit. Therefore Zanaflex was not medically necessary.

Lidoderm 5% patches #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56-57.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics, Lidoderm Page(s): 112.

Decision rationale: MTUS Chronic pain Medical Treatment Guidelines for topical analgesics for Lidoderm indicated it was recommended for localized neuropathic peripheral pain after there had been evidence of a trail of first-line therapy such as tri-cyclic antidepressant, SNRI (serotonin norepinephrine reuptake inhibitor) antidepressants or AED (antiepileptic drugs). Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. The documentation provided did not include one of the recommended indications above. There was no evidence of prior trail of first line medications as referenced above. There was no evidence of a comprehensive pain assessment and evaluation. There was no evidence of efficacy with the use of this medication. Therefore Lidoderm was not medically necessary.