

Case Number:	CM15-0163404		
Date Assigned:	09/08/2015	Date of Injury:	04/16/2010
Decision Date:	10/07/2015	UR Denial Date:	07/31/2015
Priority:	Standard	Application Received:	08/20/2015

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 34 year old female who sustained an industrial injury on 4-16-10. The Panel Qualified Medical Re-Evaluation, dated 7-30-15, indicates that her initial complaint was the onset of the inability to use her right hand due to stiffness and swelling that extended into the more proximal aspect of the right upper extremity. She, subsequently, had tingling, jerking movements, and sensitivity to cold in that extremity. The injury was caused due to a door crushing her hand. She was diagnosed with complex regional pain syndrome. The report indicates that her initial claim involved the right middle finger and "her psyche". It states that her "symptoms extended from the involved digit to other parts of her body, and because of chronic pain she reported being quite depressed". Following the injury, she was evaluated by her primary care provider. She was referred to "an upper extremity specialist", then to an orthopedic surgeon. She was treated with "aggressive therapy and medication". X-rays of the right hand were completed without evidence of fracture. She was diagnosed with "contusion to the right hand and digits, proximal interphalangeal joints". In April 2010, she was referred to hand therapy. She remained symptomatic and repeat x-rays of the right hand were completed. No abnormalities were found. She was placed on modified duty and periodically presented to providers for follow-up. She was noted to have difficulty with several providers in establishing trusting relationships. In November 2010, she was evaluated by another orthopedic surgeon. Her diagnosis of complex regional pain syndrome continued. She was prescribed Neurontin and Arthrotec and referred to pain management. The primary treating physician recommended an electrical stimulation unit for home use on 12-30-10. She was re-evaluated by occupational

therapy on 1-26-11. In February 2011, there was no improvement noted and in March 2011, she was using an H-wave stimulator, recommended by occupational therapy. In June 2011, stellate ganglion blocks were recommended, as well as cognitive behavioral counseling. In July 2011, she was also noted to have a diagnosis of "ensuing signs of very severe depression and anxiety that require a psychiatric assessment and treatment as soon as possible". The PR-2, dated 7-16-15, indicates that she reported "persistent right upper extremity pain still severe and constant, worse since reduction of her medications". The report states, "she indicates that reduction in her medication is malpractice and illegal". The report indicates that she engaged in confrontation with the provider regarding her treatment and her medications, indicating extreme dissatisfaction. She had consulted with her primary care provider and was placed on Lexapro. The report indicates that he "is unable to have treatment of her depression under workman's comp". The treatment plan was to continue Cymbalta, which was previously ordered by the examining provider. There was suspicion that she was not taking the medication as prescribed. The report states, "arrangements have been made" for her to see a psychiatrist on 9-30-15. It also indicates that she was to be evaluated by pain management. The requested medications of Omeprazole, Clonazepam, and Fentanyl patches were not discussed in the latest PR-2. The documentation for these medications is unavailable for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 40 mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms and Cardiovascular Risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID
Page(s): 68.

Decision rationale: The California chronic pain medical treatment guidelines section on NSAID therapy and proton pump inhibitors (PPI) states: Recommend with precautions as indicated below. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastro duodenal lesions. Recommendations: Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. There is no documentation provided that places this patient at intermediate or high risk that would justify the use of a PPI. There is no mention of current gastrointestinal or

cardiovascular disease. For these reasons, the criteria set forth above per the California MTUS for the use of this medication has not been met. Therefore, the request is not medically necessary.

Clonazepam 1mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines benzodiazepines Page(s): 24.

Decision rationale: The California chronic pain medical treatment guidelines section on benzodiazepines states: Benzodiazepines not recommended 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, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. (Baillargeon, 2003) (Ashton, 2005). The chronic long-term use of this class of medication is recommended in very few conditions per the California MTUS. There is no evidence however of failure of first line agent for the treatment of anxiety or insomnia in the provided documentation. For this reason, the request is not medically necessary.

Fentanyl patch 23 mcg #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80.

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 for ongoing management: 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 non-opioid 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. When to Continue Opioids, (a) If the patient has returned to work, (b) If the patient has improved functioning and pain (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004). The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documentation of significant subjective improvement in pain such as VAS scores. There is also no objective measure of improvement in function. For these reasons, the criteria set forth above of ongoing and continued used of opioids have not been met. Therefore, the request is not medically necessary.