

Case Number:	CM15-0185825		
Date Assigned:	09/28/2015	Date of Injury:	03/12/2001
Decision Date:	11/18/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application Received:	09/21/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 41 year old female, who sustained an industrial injury on 03-12-2001. The injured worker was diagnosed as having complex regional pain syndrome. On medical records dated 08-12-2015, 07-08-2015 and 03-31-2015, the subjective complaints were noted as that functional status was noted as sitting was okay, standing 30 minutes and walking 30 minutes. Injured worker wakes 4-5 times per night secondary to pain. Injured worker was noted to require some assistance with activities of daily living. Urine drug test was noted as consistent with current therapy. Physical findings were noted as pain was 7 out of 10. The injured worker was noted as neatly groomed, clear, cogent, and unimpaired by medication, sits stiffly in chair with arm elevated on a pillow for comfort, good eye contact, and flat affect. Treatments to date included medication, intrathecal drug delivery system, pain psychologist, hyperbaric oxygen, Stellate ganglion block and bier block. Current medications were not listed on 08-12-2015. The Utilization Review (UR) was dated 08-27-2015. The UR submitted for this medical review indicated that the request for Carbamazepine (Tegretol) 200mg #120, Celebrex (Celecoxib) 200mg#30, Effexor ER (Venlafaxine HCL Er) 225mg #30, Topamax (topiramate) 100mg #90, Trazadone (Desyrel) 100mg #90 were all non-certified and Risperidone (Risperdal) 2mg #30 was modified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Carbamezapine (Tegretol) 200mg #120 Rf: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: Carbamazepine is an anti-epileptic drug which can be utilized for neuropathic pain. Regarding request for the anti-epileptic drug in dispute, the Chronic Pain Medical Treatment Guidelines state that antiepileptic drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is no identification of any specific analgesic benefit (in terms of percent reduction in pain or reduction of NRS), and no documentation of specific objective functional improvement. Although there is documentation of CRPS, which would be an appropriate indication for an AED, there is no clear documentation of the amount of pain reduction attributable to this AED. Additionally, there is no discussion regarding side effects from this medication. In the absence of such documentation, the currently requested medication is not medically necessary. Note that this medication should be weaned slowly per the requesting provider's discretion, or if the requisite information on pain improvement is supplied, then this medication could be continued in that case. Therefore is not medically necessary.

Celebrex (Celecoxib) 200mg #30 RF: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: Regarding the request for Celebrex, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Celebrex is recommended for patients at intermediate to high risk for gastrointestinal events with no cardiovascular disease. Page 22 of the CPMTG states "COX-2 inhibitors (e.g., Celebrex) may be considered if the patient has a risk of GI complications, but not for the majority of patients." Within the documentation available for review, there is no indication that Celebrex is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale), or any objective functional improvement. The patient is currently on multiple adjuvant pain medications and it is not clear whether this has any benefit. Given this, the currently requested Celebrex is not medically necessary.

Effexor Er (Venlafaxine Hcl Er) 225mg #30 Rf: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain, SSRIs (selective serotonin reuptake inhibitors).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain.

Decision rationale: Effexor is a SNRI medication indicated for depression, anxiety, and also neuropathic pain (non-FDA label). Regarding the request for SNRI, the CPMTG on page 105 states the following regarding SNRIs (serotonin noradrenaline reuptake inhibitors) "Recommended as an option in first-line treatment of neuropathic pain, especially if tricyclics are ineffective, poorly tolerated, or contraindicated. See Antidepressants for chronic pain for general guidelines, as well as specific SNRI listing for more information and references. See also Venlafaxine (Effexor) and Duloxetine (Cymbalta)." Further guidelines and FDA indications approve the use of SNRI for the treatment of major depression. The ACOEM Stress Related Conditions Chapter states that "a standardized mental status examination allows the clinician to detect clues to an underlying psychiatric disorder, assess the impact of stress, and document a baseline of functioning." Furthermore, monitoring for side effects is important, and consideration for referral for medication evaluation may be "worthwhile" given the complexity of these agents. In the case of this injured worker, there is documentation of severe chronic pain and complex regional pain syndrome. However, the efficacy of Effexor is not apparent in the submitted documentation. There should be documentation of the analgesic effect of this medication or its effect on the worker's mood. In terms of mood, there should be serial psychiatric examinations with possible inclusion of metrics such as the Beck Depression Inventory to ascertain the efficacy of this medication. Without this documentation, this request is not medically necessary.

Risperidone (Risperdal) 2 Mg #30 Rf: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter & Mental Illness and Stress Chapter, Atypical Anti-Psychotic Topic and Other Medical Treatment Guidelines UpToDate Online, Risperdal.

Decision rationale: With regard to the request for Risperdal, this is an atypical anti-psychotic medication that is not directly addressed by the CA MTUS. The ODG Mental Illness and Stress Chapter states the following regarding atypical anti-psychotics: "Not recommended as a first-line treatment. There is insufficient evidence to recommend atypical antipsychotics (eg, quetiapine, risperidone) for conditions covered in ODG. See PTSD pharmacotherapy. Adding an atypical antipsychotic to an antidepressant provides limited improvement in depressive symptoms in

adults, new research suggests. The meta-analysis also shows that the benefits of antipsychotics in terms of quality of life and improved functioning are small to nonexistent, and there is abundant evidence of potential treatment-related harm. The authors said that it is not certain that these drugs have a favorable benefit-to-risk profile. Clinicians should be very careful in using these medications. (Spielmans, 2013) The American Psychiatric Association (APA) has released a list of specific uses of common antipsychotic medications that are potentially unnecessary and sometimes harmful. Antipsychotic drugs should not be first-line treatment to treat behavioral problems."In the case of this injured worker, there is insufficient documentation as to the efficacy and benefit of this medication in the treatment regimen. This medication is primarily indicated for schizophrenia and bipolar disorder, but can also be used as adjuvant therapy for depression. The patient is noted already to be on an antidepressant (Effexor), but there are no serial assessments of depression symptoms included for review. Given this, this request is not medically necessary.

Topamax (Topiramate) 100mg #90 Rf: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: Topomax is an anti-epileptic drug that is also utilized in various chronic pain states including migraines and neuropathic pain states. Regarding request for the anti-epileptic drug in dispute, the Chronic Pain Medical Treatment Guidelines state that antiepileptic drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is no identification of any specific analgesic benefit (in terms of percent reduction in pain or reduction of NRS), and no documentation of specific objective functional improvement. Additionally, there is no discussion regarding side effects from this medication. In the absence of such documentation, the currently requested medication is not medically necessary.

Trazadone (Desyrel) 100mg #90 RF: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter & Mental Illness and Stress Chapter, Insomnia Topics.

Decision rationale: Regarding the request for Trazodone, this drug is a serotonin reuptake inhibitor and can be utilized for many indications. In the records, it is not apparent whether this drug is being utilized to address depression, pain, or insomnia. The California MTUS guidelines have general guidelines for the use of antidepressants for pain, but are silent regarding the use of Trazodone for insomnia management. The ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. The guidelines further stipulate that failure of sleep disturbances to resolve in 7 to 10 days may indicate a psychiatric or medical illness. There is a recommendation for non-pharmacologic modalities to address insomnia including education on sleep hygiene. It is recommended that treatments for insomnia should reduce time to sleep onset, improve sleep maintenance, avoid residual effects and increase next-day functioning. Within the documentation available for review, there is no discussion regarding how frequently the insomnia complaints occur or how long they have been occurring, no statement indicating what behavioral treatments have been attempted for the condition of insomnia, and no statement indicating how the patient has response to the medication in question. Furthermore, if the primary indication is for the treatment of depression, it is noted that no specific beneficial response is noted to this medication. Given this, the current request is not medically necessary.