

Case Number:	CM15-0034996		
Date Assigned:	03/03/2015	Date of Injury:	05/02/2013
Decision Date:	04/20/2015	UR Denial Date:	02/16/2015
Priority:	Standard	Application Received:	02/24/2015

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: Anesthesiology

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 47 year old female injured worker suffered an industrial injury on 5/2/2013. The diagnoses were bilateral wrist sprain. The diagnostic studies were magnetic resonance imaging of the bilateral upper extremities and electromyography/nerve conduction velocity. The treatments were elbow injections, medications, acupuncture, and wrist bracing. The treating provider reported complained of swelling and pain of the left wrist that were moderately severe with burning, numbness, decreased sensation and weakness. The Utilization Review Determination on 2/16/2015 non-certified: 1. Follow-up consultation, wrists, per 01/26/15 order, Qty: 1.00, MTUS ACOEM, 2. Ultram ER 150mg, Qty 30.00 MTUS, 3. Anaprox DS 550mg Qty 60.00 MTUS, 4. Neurontin 600 mg , Qty: 60.00 MTUS, 5. Sonata 10 mg Qty: 30.00, ODG.

IMR ISSUES, DECISIONS AND RATIONALES

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

Follow-up consultation, wrists, per 01/26/15 order, Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268.

Decision rationale: Patients with potentially work-related forearm, wrist, and hand complaints should have follow-up every three to five days by a mid-level practitioner, or by a physical or hand therapist who can counsel them about avoiding static positions, medication use, activity modification, and other concerns. In this case, there is no documentation to support this diagnosis that occurred 2 years ago. Medical necessity for the follow-up evaluation has not been established. The requested follow-up evaluation is not medically necessary.

Ultram ER 150mg, Qty 30.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 93-94, 78-80, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the California MTUS, Ultram (Tramadol) is a synthetic opioid, which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. According to the medical records, there has been no documentation of the medication's analgesic effectiveness, functional improvement, and no clear documentation that the patient has responded to ongoing opioid therapy. In addition, there is no documentation of acute pain or an acute exacerbation of chronic pain. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic requires a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

Anaprox DS 550mg Qty 60.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67, 68, 73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

Decision rationale: Anaprox (Naproxen) is a non-steroidal anti-inflammatory drug (NSAID). Oral NSAIDs are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. ODG states that NSAIDs are recommended for acute pain, osteoarthritis, acute low back pain (LBP) and acute exacerbation of chronic pain, short-term pain relief in chronic LBP, and short-term improvement of function in chronic LBP. There

is no evidence of long-term effectiveness for pain or function. There is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain. Guidelines recommend that the lowest effective dose be used for the shortest duration of time consistent with treatment goals. In this case, the patient had prior/intermittent use of NSAIDs without any documentation of significant improvement. There was no documentation of subjective or objective functional benefit from use of this medication. Medical necessity of the requested medication has not been established. The request for Anaprox is not medically necessary.

Neurontin 600 mg , Qty: 60.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18-19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy Drugs (AEDs), Gabapentin (Neurontin) Page(s): 17-19, 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neurontin.

Decision rationale: According to the CA MTUS (2009) and ODG, Gabapentin (Neurontin) is an anti-epilepsy drug (AED) which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia, and has been considered as a first-line treatment for neuropathic pain. This medication appears to be effective in reducing abnormal hypersensitivity (allodynia and hyperalgesia), to have anti-anxiety effects, and may be beneficial as a sleep aid. In this case, there is no documentation of neuropathic pain. In addition, there is no documentation of the medication's pain relief effectiveness, or functional benefit. Medical necessity of the requested medication has not been established. The requested medication is not medically necessary.

Sonata 10 mg Qty: 30.00: 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), Pain.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Sedative hypnotics, Insomnia treatment and Other Medical Treatment Guidelines American Academy of Sleep Medicine (AASM, 2015).

Decision rationale: Sonata (Zaleplon) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually three weeks) treatment of insomnia and is not recommended for long-term use. It can be habit-forming, and may impair function and memory and may increase pain and depression over the long-term. The treatment of insomnia should be based on the etiology and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. The American Academy of Sleep Medicine (AASM, 2015) advises against use of hypnotics as primary therapy for chronic insomnia. In this case, the provider has been prescribing Sonata for chronic or long-term use. Sonata is not indicated for long-term use. There is no documentation of functional improvement with prior

use of Sonata. Medical necessity of the requested medication has not been established. The requested medication is not medically necessary.