

Case Number:	CM15-0051265		
Date Assigned:	03/24/2015	Date of Injury:	05/22/2006
Decision Date:	05/13/2015	UR Denial Date:	03/09/2015
Priority:	Standard	Application Received:	03/18/2015

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

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 53-year-old female who reported an injury on 05/22/2008. The mechanism of injury was not specifically stated; however, it was noted that the injured worker suffered a gradual onset of carpal tunnel syndrome. The current diagnoses include complex regional pain syndrome, cervicocranial syndrome, cervical disc protrusion, mild degenerative changes of the cervical spine, cervical sprain with myofasciitis, thoracic sprain, and lumbar sprain with myofasciitis and aggravation of pre-existing right upper extremity complaints. The injured worker presented on 03/12/2015 for a follow-up evaluation with complaints of significant pain in the right upper extremity. The injured worker also reported symptoms involving the left upper and lower extremities. The current medication regimen includes Lyrica 75 mg, Percocet 10/325 mg, Cymbalta 60 mg and Lunesta 2 mg. It was noted that the injured worker random urinary drug screen was consistent with the prescribed medications as of 02/12/2015. The injured worker's CURES report was also consistent with medication as of 03/11/2015. The injured worker does have an opioid that had been rereviewed on 02/12/2015. The injured worker reported 9+/10 pain without medication and 6/10 pain with medication. Upon examination, there was evidence of CRPS in the right upper extremity, extending slightly into the left hand and down into the left foot. The left foot was extremely painful to touch and movement, specifically over the lateral metatarsals. No further examination was attempted. Treatment recommendations included a ketamine infusion, a brachial plexus nerve block, and a lumbar sympathetic nerve block, x-rays of the left foot and continuation of the current medication regimen. A Request for Authorization form was then submitted on 03/12/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lunesta 2 MG Tabs Qty30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment.

Decision rationale: The Official Disability Guidelines recommend insomnia treatment based on etiology. Lunesta has demonstrated reduced sleep latency and sleep maintenance. In this case, it is noted that the injured worker has continuously utilized Lunesta 2 mg at bedtime since at least 07/2014. There is no mention of functional improvement despite the ongoing use of this medication. Guidelines do not support long-term use of hypnotics. In addition, there was no frequency listed in the request. Therefore, the request is not medically appropriate at this time.

Ketamine 5 Percent Cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56.

Decision rationale: The California MTUS Guidelines do not recommend ketamine. There is insufficient evidence to support the use of ketamine for the treatment of chronic pain. There are no quality studies to support the use of ketamine for chronic pain and it is currently under study for CRPS. More studies are needed to further establish the safety and efficacy of this drug. Therefore, the request cannot be determined as medically appropriate. In addition, there was no specific frequency or quantity listed in the request. As such, the request is not medically appropriate at this time.

Lipoderm Topical Cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: California MTUS Guidelines state lidocaine is not recommended in the form of a cream, lotion or gel. Therefore, the request for a Lipoderm topical cream cannot be

determined as medically appropriate. In addition, there was no specific frequency or quantity listed in the request. As such, the request is not medically appropriate at this time.

Zofran 4 MG Tabs Qty 20: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Ondansetron, Antiemetic.

Decision rationale: The Official Disability Guidelines do not recommend ondansetron for nausea and vomiting secondary to chronic opioid use. It has been FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment. The injured worker does not meet criteria as outlined by the Official Disability Guidelines. In addition, Zofran was not part of the injured worker's current medication list. There is no indication that this injured worker is currently utilizing Zofran 4 mg. In addition, there was no frequency listed in the request. As such, the request is not medically appropriate at this time.

6 Chiropractic Treatments for Lumbar Spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

Decision rationale: California MTUS Guidelines recommend manual therapy and manipulation for chronic pain if caused by a musculoskeletal condition. Treatment for the low back is recommended as a therapeutic trial of 6 visits over 2 weeks. In this case, there was no documentation of the previous course of chiropractic therapy with evidence of objective functional improvement. Therefore, additional treatment would not be supported. In addition, there was no comprehensive physical examination of the lumbar spine provided on the requesting date. Given the above, the request is not medically appropriate at this time.

Walker with Seat and Basket: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Walking Aid.

Decision rationale: The Official Disability Guidelines recommend assistive devices as needed. Assisted devices for ambulation can reduce pain associated with osteoarthritis. In this case, there was no comprehensive physical examination provided. The physician noted evidence of CRPS in the right upper extremity, extending into the left upper and lower extremities with pain over the lateral metatarsal. There was no indication that this injured worker required an assistive device for ambulation. As the medical necessity has not been established, the request is not medically appropriate at this time.

Percocet 10 MG/325 MG Tabs Qty 180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until a patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects should occur. In this case, there was no documentation of objective functional improvement despite the ongoing use of this medication. There is no comprehensive physical examination provided. The request as submitted also failed to indicate a specific frequency. Therefore, the request is not medically appropriate at this time.