

Case Number:	CM14-0128910		
Date Assigned:	09/08/2014	Date of Injury:	01/01/2008
Decision Date:	10/10/2014	UR Denial Date:	07/09/2014
Priority:	Standard	Application Received:	08/13/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations

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 51-year-old female with a reported date of injury of 01/01/2008. The mechanism of injury was not provided. The injured worker's diagnoses include recurrent triggering of the right ring finger, right index finger triggering, chronic pain syndrome, depression, and sleep difficulty. The injured worker's past treatments have included medications, rehabilitative therapy, home exercise program, ice application, and immobilization with a thumb brace. The injured worker has had psychological testing. The injured worker's surgical history included left second finger trigger release on 06/02/2011, right ring finger trigger release in February 2009, left third and fourth trigger release on 05/06/2010, left index finger trigger release on 06/02/2011, and right thumb trigger release on 07/22/2014. On 06/27/2014 the clinician prescribed Compazine. There is a mention of gastrointestinal distress and a pill that dissolves in the mouth, but no documentation of nausea or vomiting. The gastrointestinal examination is marked as negative. The injured worker was evaluated on 08/22/2014 where she rated her pain as 6/10 with medication and 7-8/10 without medication. She reported one and one-half hours of relief with medications. The injured worker reported she was able to perform activities of daily living but complained of difficulty sleeping. The clinician observed and reported a focused right thumb examination as post-operative changes at the A1 pulley region, tenderness to palpation, no triggering, and limited range of motion. The clinician prescribed Ultram ER and Sonata. The injured worker's medications included Norco 10/325mg, Remeron 15mg, Compazine 10mg, Ultram ER, and Sonata. The requests were for 1 prescription of Compazine 10mg #60, 1 prescription of Remeron 15mg #30, and 1 prescription of Norco 10/325mg #120. No rationale was provided for these requests. Request for Authorization forms for Norco 10/325mg were submitted on 01/13/2014, 04/07/2014, 05/20/2014, 06/27/2014 and 08/06/2014. Request for Authorization forms for Remeron 15mg were submitted on 05/20/2014

and 06/27/2014. The request for authorization form for Compazine was submitted on 06/27/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective request for 1 prescription of Norco 10/325mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78.

Decision rationale: The request for 1 prescription of Norco 10/325mg #120 is not medically necessary. The injured worker rated her pain as 6/10 with medication and 7-8/10 without medication and reported one and one-half hours of relief with medications at her last evaluation. The California MTUS guidelines recommend ongoing review, with 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 guidelines also recommend that providers assess for side effects and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. The requesting physician did not provide documentation of an adequate and complete assessment of the injured worker's pain. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. Therefore, the request for 1 prescription of Norco 10/325mg #120 is not medically necessary.

Prospective request for 1 prescription of Remeron 15mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness & Stress

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-14.

Decision rationale: The request for 1 prescription of Remeron 15mg #30 is not medically necessary. The injured worker rated her pain as 6/10 with medication and 7-8/10 without medication and reported one and one-half hours of relief with medications at her last evaluation. The California MTUS Chronic Pain Guidelines recommend antidepressants as a first-line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclic antidepressants are generally considered a first-line agent unless they are ineffective, poorly tolerated, or

contraindicated. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Side effects, including excessive sedation (especially that which would affect work performance), should be assessed. Remeron is classified as a tetracyclic antidepressant. There is no provided documentation of a trial of a tricyclic antidepressant; and, on 08/22/2014, the clinician prescribed Sonata in place of the Remeron. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. Therefore, the request for 1 prescription of Remeron 15mg #30 is not medically necessary.

Prospective request for 1 prescription of Compazine 10mg #60: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Anti-emetics (for opioid nausea)

Decision rationale: The request for 1 prescription of Compazine 10mg #60 is not medically necessary. On the clinic note dated 06/27/2014, there was a mention of gastrointestinal distress; however, there is a lack of documentation of nausea or vomiting. The gastrointestinal examination was noted as negative. The Official Disability Guidelines do not recommend antiemetics for nausea and vomiting secondary to chronic opioid use. There is a lack of documentation indicating the injured worker has significant nausea and vomiting. There is a lack of documentation indicating how long any such symptoms have been present. The requesting physician's rationale for the request is not indicated within the provided documentation. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. Therefore, the request for 1 prescription of Compazine 10mg #60 is not medically necessary.