

Case Number:	CM15-0001465		
Date Assigned:	01/12/2015	Date of Injury:	03/30/2007
Decision Date:	03/12/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/05/2015

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:

This a female injured worker who reported an injury on 03/30/2007. The injured worker reportedly suffered a gradual onset of bilateral foot pain. The current diagnoses include CRPS right lower extremity and status post right total knee replacement. The injured worker presented on 12/11/2014 with complaints of right foot right. The current medication regimen includes amitriptyline 25 mg, fentanyl 50 mcg, fentanyl 12 mcg, Lunesta 3 mg, Neurontin 600 mg, Prilosec 20 mg, and Percocet 10/325 mg. Upon examination, there was swelling and edema in the right foot/ankle, erythema of right foot, hypersensitivity at the dorsum of the right foot, and 3/5 motor weakness. Recommendations at that time included continuation of the current medication regimen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro (DOS 11/13/14): Lunesta 3mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Med Lett Drugs (Eszopiclone)

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. The injured worker has continuously utilized Lunesta since 06/2014 without mention of functional improvement. There is no documentation of a failure of nonpharmacologic treatment as recommended by the Official Disability Guidelines. There is also no frequency listed in the request. As such, the request is not medically appropriate.

Retro (DOS 11/13/14): Neurontin 600mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-19.

Decision rationale: California MTUS Guidelines state gabapentin is recommended for treatment of diabetic painful neuropathy and postherpetic neuralgia, and has also been considered as a first line treatment for neuropathic pain. While it is noted that the injured worker maintains a diagnosis of CRPS in the right lower extremity, it is also noted that the injured worker has utilized this medication since 06/2014 without any evidence of objective functional improvement. Additional use cannot be determined as medically appropriate in this case. There is also no frequency listed in the request. Therefore, the request is not medically appropriate.

Retro (DOS 11/13/14): Prilosec (quantity & dosage unspecified): 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) Treatment in Workers Compensation (TWC); Proton Pump Inhibitors (PPI's)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the injured worker does not meet criteria for the requested medication. Additionally, there was no strength, frequency, or quantity listed in the request. As such, the request is not medically appropriate.

Retro (DOS 11/13/14): Amitriptyline 25mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

Decision rationale: California MTUS Guidelines state amitriptyline is recommended for neuropathic pain. While it is noted that the injured worker maintains a diagnosis of CRPS of the right lower extremity, it is also noted that the injured worker has utilized amitriptyline 25 mg since 06/2014. There is no documentation of objective functional improvement. There is also no frequency listed in the request. As such, the request is not medically appropriate.