

<b>Case Number:</b>	CM15-0004276		
<b>Date Assigned:</b>	01/15/2015	<b>Date of Injury:</b>	01/11/1994
<b>Decision Date:</b>	03/24/2015	<b>UR Denial Date:</b>	12/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/08/2015

### 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: Internal Medicine

### 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 52-year-old female who sustained a work related injury on January 11, 1994 after a trip and fall injuring her right upper extremity and both knees. A spinal cord stimulator was placed in 1995 and diagnosed with reflex sympathy dystrophy of the entire right arm. It was removed in 2004, because it was no longer effective. She later developed carpal tunnel syndrome and headaches. Treatments included physical therapy and medications. Later in 2013, she continued with reoccurring arm, wrist and upper extremities pain and limitations. Diagnoses included hand and wrist tendonitis, chronic pain syndrome, migraine headaches, opiate tolerance and myofascial pain. Currently, the injured worker complains of ongoing upper extremity pain and discomfort. On December 11, 2014, utilization review modified to a certification of 1 prescription of Sumavel Dosepro 6 milligrams/0.5 #5 with 1 refill between December 5, 2014 and March 8, 2015; modified to a certification of 1 prescription of Amitriptyline HCL 50 milligrams #60 with 1 refill between December 5, 2014 and March 8, 2015; non-certified a request for 1 prescription of Lidoderm patches 5% #60 with 2 refills; modified to a certification of 1 prescription of Meloxicam 7.5 milligrams #60 with 1 refill between December 5, 2014 and March 8, 2015; non-certified a request for 1 Torodol injection 30 milligrams between December 5, 2014 and December 5, 2014; non-certified a request for 1 Vitamin B1, B6 and B12 solution injection between December 5, 2014 and December 5, 2014; and non-certified a request for 1 Torodol injection-third injection between December 5, 2014 and December 5, 2014, noting the CA MTUS Guidelines.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Sumavel dosepro 6mg/0.5ml #5 with 2 refills:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Not addressed. Decision based on Non-MTUS Citation UpToDate

**Decision rationale:** Sumavel is used in the treatment of migraine headaches. The injured worker reports good result with current medication regimen in treating symptoms, which in turn would justify continued use of this medication. Per guidelines, the request for Sumavel dosepro 6mg/0.5ml #5 with 2 refills is medically necessary.

**Amitriptyline HCL 50mg #60 with 2 refills:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13 to 16. Decision based on Non-MTUS Citation Drug Formulary

**Decision rationale:** Amitriptyline is a tricyclic antidepressant. Tricyclics are recommended as first-line treatment for neuropathic pain unless they are ineffective, poorly tolerated, or contraindicated. Chart documentation indicates that the medication is tolerated and effective in controlling the injured worker's neuropathic upper extremity pain. In the absence of failed therapy and the documentation that the injured worker is able to perform activities of daily living in response to current medication regimen, the request for Amitriptyline HCL 50mg #60 with 2 refills is medically necessary.

**Lidoderm patches 5% #60 with 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** MTUS states that use of topical analgesics is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Lidoderm patch is not recommended as first line treatment and is only FDA approved for post-herpetic neuralgia. Documentation does not demonstrate that use of this medication is indicated. The request for Lidoderm patches 5% #60 with 2 refills is not medically necessary based on MTUS.

**Meloxicam 7.5mg #60 with 2 refills:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines non-steroidal anti-inflammatory drugs Page(s): 67.

**Decision rationale:** Per MTUS guideline, Non-steroidal anti-inflammatory drugs (NSAIDS) are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. The injured worker's chronic pain is reported to be controlled with current medication regimen with no adverse side effects. Additionally, there is no evidence that the injured worker is at risk for gastrointestinal events. The request for Meloxicam 7.5mg #60 with 2 refills is medically necessary.

**1 Toradol injection-30mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines non-steroidal anti-inflammatory drugs Page(s): 67. Decision based on Non-MTUS Citation Drug Formulary

**Decision rationale:** Per guidelines, Non-steroidal anti-inflammatory drugs (NSAIDS) are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Toradol (Ketorolac) is recommended in the management of moderately severe acute pain that requires analgesia at the opioid level. It is not indicated for minor or chronic painful conditions. Chart documentation fails to indicate that the injured worker presented with acute exacerbation of chronic pain that would warrant the administration of Toradol. The request for 1 Toradol injection 30 milligrams is not medically necessary

**1 Vitamin B1 (100mg), B6 and B12 (1000mcg) solution injection:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Not addressed. Decision based on Non-MTUS Citation UpToDate

**Decision rationale:** Documentation indicates that the injured worker has chronic neuropathic upper extremity pain. There are no established guidelines recommending the use of Vitamin B1,

B6 or B12 in the treatment of neuropathic pain. The request for 1 Vitamin B1 (100mg), B6 and B12 (1000mcg) solution injection is not medically necessary.

**1 Toradol injection-third injection:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines non-steroidal anti-inflammatory drugs Page(s): 67. Decision based on Non-MTUS Citation Drug Formulary

**Decision rationale:** Per guidelines, Non-steroidal anti-inflammatory drugs (NSAIDS) are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Toradol (Ketorolac) is recommended in the management of moderately severe acute pain that requires analgesia at the opioid level. It is not indicated for minor or chronic painful conditions. Chart documentation fails to indicate that the injured worker presented with acute exacerbation of chronic pain that would warrant the administration of Toradol. The request for 1 Toradol injection-third injection is not medically necessary.