

Case Number:	CM15-0177895		
Date Assigned:	09/18/2015	Date of Injury:	05/15/2007
Decision Date:	10/28/2015	UR Denial Date:	09/08/2015
Priority:	Standard	Application Received:	09/09/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 65 year old female who sustained an industrial injury on 05-15-2007. Diagnoses include complex regional pain syndrome bilaterally and bilateral shoulder-hand syndrome. A physician progress note dated 08-28-2015 documents the injured worker presents for follow up on right upper extremity complex regional pain syndrome. She takes oral NSAIDs, but she would prefer to use topical NSAIDs instead to prevent gastrointestinal upset. She notes significant improvement with pain and insomnia with the trial of Trazodone and she will continue this prescribed medication. She notes greater than 50% improvement with use of the Transcutaneous Electrical Nerve Stimulation unit in the past, but she has not had the supplies for its use. A physician progress noted dated 06-27-2015 documents the injured worker complains of pain in her both upper extremities-shoulders to her hands. It is described as a burning and numbness. Her pain is constant and variable in intensity. She has hypersensitivity to touch in the affected areas. Treatment to date has included diagnostic studies, medications, use of a Transcutaneous Electrical Nerve Stimulation unit, status post left shoulder surgery, right trigger thumb release, left wrist surgery x 2, and left hip surgery. Current medications include Aleve, Ibuprofen, Trazodone, Tylenol ES, and Voltaren 1% gel (not using-insurance not covering). The treatment plan included encouraging her to continue with her home exercise program. On 09-08-2015 the Utilization Review non-certified the request for Aleve 220mg #60 with 3 refills, TENS unit supplies and Trazodone 50mg #30 with 3 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS unit supplies: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines do not recommend TENS as a primary treatment modality, but support consideration of a one-month home-based TENS trial used as an adjunct to a program of evidence-based functional restoration. Furthermore, criteria for the use of TENS includes pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, and a documented one-month trial period stating how often the unit was used, as well as outcomes in terms of pain relief and function. The injured worker is diagnosed with right upper extremity CRPS. It was noted per the medical records that she utilizes a TENS unit which provides greater than 50% improvement. I respectfully disagree with the UR physician's denial based upon a lack of pain diary documenting functional improvement. Per the guidelines, this is only mandated during a trial. As it is reasonably expected that TENS unit supplies will degrade, the request is medically necessary.

Trazodone 50mg #30 with 3 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress (updated 08/31/2015), online version.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Insomnia Treatment.

Decision rationale: Per MTUS CPMTG with regard to the use of antidepressants for chronic pain: "Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. (Feuerstein, 1997) (Perrot, 2006) Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. 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." With regard to insomnia treatment, the ODG guidelines state "Sedating antidepressants (e.g., amitriptyline, trazodone, mirtazapine) have also been used to treat insomnia; however, there is less evidence to support their use for insomnia (Buscemi, 2007) (Morin, 2007), but they may be an option in patients with coexisting depression. (Morin, 2007) Trazodone is one of the most commonly prescribed agents for insomnia. Side effects of this drug include nausea, dry mouth, constipation, drowsiness, and

headache. Improvements in sleep onset may be offset by negative next-day effects such as ease of awakening. Tolerance may develop and rebound insomnia has been found after discontinuation." The documentation submitted for review indicates that the injured worker has upper extremity radicular pain as well as insomnia. It was noted that the injured worker reported significant improvement with pain and insomnia with trial of this medication. I respectfully disagree with the UR physician's assertion that there was no documentation of neuropathic pain. The request is medically necessary.

Aleve 220mg #60 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: With regard to the use of NSAIDs for chronic low back pain, the MTUS CPMTG states "Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another." "Low back pain (chronic): Both acetaminophen and NSAIDs have been recommended as first line therapy for low back pain. There is insufficient evidence to recommend one medication over the other. Selection should be made on a case-by-case basis based on weighing efficacy vs. side effect profile." As this medication is only recommended for short-term symptomatic relief, the request for 4 month supply is not appropriate and is not medically necessary.