MAXIMUS Federal Services

Case Number:	CM15-0039604		
Date Assigned:	03/10/2015	Date of Injury:	07/01/1996
Decision Date:	04/20/2015	UR Denial Date:	02/23/2015
Priority:	Standard	Application Received:	03/03/2015

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
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 56 year old female, who sustained an industrial injury on 7/1/96. She reported pain in the bilateral lower extremities and back. The injured worker was diagnosed as having chronic regional pain syndrome, plantar fascitis and mild ankle sprain. Treatment to date has included physical therapy, acupuncture, TENs unit and pain medications. The injured worker fell in May of 2014 and re-injured her right knee. She was seen by an orthopedist who started her on physical therapy. As of the PR2 dated 2/16/15, the treating physician reports that the injured worker has tried and failed to benefit from standard neuropathic treatment. He requested to continue with the generic of Tambacor and have an EEG performed.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Flecainide 150mg, #180 with 3 refills: 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), Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Complex Regional Pain Syndrome (CRPS) on CRPS, medications Page(s): 35-41. Decision based on

Non-MTUS Citation Official disability guidelines Pain (Chronic) Chapter under CRPS, medications.

Decision rationale: Based on the 02/16/15 progress report provided by treating physician, the patient presents with chronic regional pain syndrome, plantar fasciitis and mild ankle sprain, and anterior talofibular ligament sprain. The request is for 1 PRESCRIPTION OF FLECAINIDE 150MG #180 WITH 3 REFILLS. RFA not provided. Treatment to date has included physical therapy, acupuncture, TENs unit and pain medications. Patient medications include Tambocor, Neurontin, Celebrex, Adderal, Cymbalta, Provigil, Xanax, Flexeril, Wellbutrin and Seveline. The patient is permanent and stationary, per treater report dated 02/16/15. MTUS Guidelines, pages 35-41, CHRONIC PAIN MEDICAL TREATMENT GUIDELINES: Complex Regional Pain Syndrome (CRPS) on CRPS, medications states: "Recommended only as indicated below. Most medications have limited effectiveness. (Ribbers, 2003) (Quisel2, 2005) 1. Regional inflammatory reaction: Commonly used drugs are NSAIDS, corticosteroids and free-radical scavengers. There is some evidence of efficacy for topical DMSO cream, IV bisphosphonates and limited courses of oral corticosteroids. Corticosteroids are most effective when positive response is obtained with sympathetic blocks. NSAIDs are recommended but no trials have shown effectiveness in CRPS-I, and they are recommended primarily in early or very late stages. (Stanton-Hicks, 2004) (Sharma, 2006)2. Stimulus-independent pain: The use of antidepressants, anticonvulsants, and opioids has been primarily extrapolated based on use for other neuropathic pain disorders. (See Antidepressants for chronic pain; Anticonvulsants for chronic pain; & Opioids for neuropathic pain.) Mexiletine, lidocaine patches and capsaicin are used but efficacy is not convincing. For central inhibition opiates, gabapentin, TCAs, GABA-enhancing drugs, and clonidine may be useful. 3. Stimulus-evoked pain: treatment is aimed at central sensitization. With NMDA receptor antagonists (ketamine and amantadine) convincing controlled trials are lacking, and these drugs are known for their side effects .4. Sympathetically maintained pain (SMP): 1 adrenoceptor blocking agents (terazosin, prazocin, and phenoxybenzamine) have been shown to be effective in a case report. (Ghostine, 1984) Sympathetic suppressors such as guanethadine, reserpine, droperidol, or atropine (in general or IV block) have shown low effectiveness. (Perez, 2001) (Quisel2, 2005) Phentolamine (IV) has been used as an alternative to determine responsiveness to 1 adrenoceptor blocking agents. See also Sympathetically maintained pain (SMP). 5. Treatment of bone resorption with bisphosphonate-type compounds and calcitonin. Significant improvement has been found in limited studies of intravenous clodronate and intravenous alendronate. Adendronate (Fosamax) given in oral doses of 40 mg a day (over an 8 week period) produced improvements in pain, pressure tolerance and joint mobility. (Manicourt DH, 2004) Mixed results have been found with intranasal calcitonin (Miacalcin). (Sahin, 2005) (Appelboom, 2002) (Rowbathan, 2006) (Sharma, 2006)" ODG-TWC, Pain (Chronic) Chapter under CRPS, medications states: "Recommended only as indicated below. Most medications have limited effectiveness, and recommendations are primarily based on extrapolation from neuropathic pain medication guidelines. A reason given for the paucity of medication studies is the absence of a gold-standard diagnostic test for CRPS and lack of uniformly accepted diagnostic criteria. (Ribbers, 2003)" Tambocor (Flecainide) has been included in patient's medications, per treater reports dated 08/11/14 and 02/16/15. Per progress report dated 02/16/15, treater states "continue use of membrane stabilizer for CRPS, Flecainide. Patient has been on this med to control her CRPS pain for >10years. She failed to benefit from standard Neuropathic meds except Neurontin, which is adequate to control

symptoms by itself." Treater is requesting Flecainide to control patient's CRPS. In this case, however, although the treater has provided a diagnosis of CRPS, there is no clear diagnosis of CRPS with positive exam findings such as hypersensitivity, dystrophic skin changes, joint stiffness or swelling, discoloration, the hallmark signs of CRPS. Furthermore, guidelines do not provide support for Tambocor (Flecainide) for the treatment of CRPS. Therefore, the request IS NOT medically necessary.

1 ECG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation EFNS guidelines on the pharmacological treatment of neuropathic pain: 2010 revision: Attal N, Cruccu G, Baron R, Hanpaa M, Hansson P, Jensen TS, Nurmikko T, European Federation of Neurological Societies. EFNS guidelines on the pharmacological treatment of neuropathic pain: 2010 revision, EUR J Neorol. 2010 Sep; 17 (9): 1113-e88 [105 references].

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation U.S. National Library of Medicine, states at http://www.nlm.nih.gov/medlineplus/ency/article/003868.htm.

Decision rationale: Based on the 02/16/15 progress report provided by treating physician, the patient presents with chronic regional pain syndrome, plantar fasciitis and mild ankle sprain, and anterior talofibular ligament sprain. The request is for 1ECG. RFA not provided. Treatment to date has included physical therapy, acupuncture, TENs unit and pain medications. Patient medications include Tambocor, Neurontin, Celebrex, Adderal, Cymbalta, Provigil, Xanax, Flexeril, Wellbutrin and Seveline. The patient is permanent and stationary, per treater report dated 02/16/15. MTUS and ACOEM guidelines do not discuss electrocardiogram. ODG guidelines discuss the procedure only in per-operative cases. MedlinePlus, a service of the U.S. National Library of Medicine, states at http://www.nlm.nih.gov/medlineplus/ency/article/003868.htm, that "An electrocardiogram (ECG) is a test that records the electrical activity of the heart." The report also states "An ECG is used to measure: Any damage to the heart; How fast your heart is beating and whether it is beating normally; The effects of drugs or devices used to control the heart (such as a pacemaker); The size and position of your heart chambers An ECG is often the first test done to determine whether a person has heart disease. Your doctor may order this test if: You have chest pain or palpitations, you are scheduled for surgery, you have had heart problems in the past, you have a strong history of heart disease in the family. There is no reason for healthy people to have yearly ECG tests." Treater has not provided reason for the request. Per progress report dated 02/16/15, treater states "Need ECG." Treater does not explain the purpose of the request. There is no documentation of any cardiovascular complications, apart from documentation that patient has been taking Tambocor (Flecaine) at least since 08/11/14, per treater report. Per report dated 02/16/15, treater states "continue use of membrane stabilizer for CRPS, Flecainid; patient has been on this med to control her CRPS pain." ECG monitoring may be appropriate for continued use of this medication but the medication is not recommended for CRPS per guidelines. The treater does not describe any heart conditions or symptoms that would require an ECG monitoring. The request IS NOT medically necessary.