

<b>Case Number:</b>	CM13-0002007		
<b>Date Assigned:</b>	05/16/2014	<b>Date of Injury:</b>	11/18/2002
<b>Decision Date:</b>	06/12/2014	<b>UR Denial Date:</b>	07/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/15/2013

### 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 Internal and Emergency Medicine and is licensed to practice in Florida. 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:

This patient is a 51 year-old with a date of injury of 11/18/02. A progress report proximate to the request for services, dated 04/23/13, identified subjective complaints of neck pain radiating into the upper extremities, low back pain, and bilateral shoulder pain. Objective findings included tenderness of the shoulders with decreased range-of-motion. There was tenderness of the lumbar spine and decreased range-of-motion. Motor function was normal. Diagnoses included lumbar disc disease; status-post cervical fusion with radiculopathy; and bilateral shoulder impingement syndrome. Treatment has included oral analgesics.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **UNKNOWN SESSIONS OF MEDICATION MANAGEMENT (ONCE EVERY 3 MONTHS FOR 2 YEARS OR MORE): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 405.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions & Treatment, Opioids Page(s): 11, 79, 89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Office Visits.

**Decision rationale:** The Medical Treatment Utilization Schedule (MTUS) notes that patients on controlled substances should be seen monthly, quarterly, or semiannually as required by the standard of care (California, 1994). Elsewhere they state that there is no set visit frequency. It should be adjusted to the patient's need for evaluation of adverse effects, pain status, and appropriate use of medication, with recommended duration between visits from 1 to 6 months. They further recommend that the duration of continued medication treatment for chronic pain depends on the physician's evaluation of progress toward treatment objectives. The Official Disability Guidelines (ODG) state that the need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. They further note that patient conditions are extremely varied and that a set number of office visits per condition cannot be reasonably established. In this case, the request is too broad in duration and lacks specificity for their scope. Therefore, the documentation does not justify the medical necessity for medication management visits as particularly requested.

**XANAX 0.5MG #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 1065-1066.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines BENZODIAZEPINES Page(s): 24.

**Decision rationale:** Xanax (alprazolam) is a benzodiazepine anxiolytic. The Medical Treatment Utilization Schedule (MTUS) state that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. They further note that that they are the treatment of choice in very few conditions. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. In this case, there is documentation of longer-term use. Therefore, the record lacks documentation for the medical necessity of alprazolam (Xanax).

**AMBIEN 10MG #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Mental Illness & Stress.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter, Insomnia Treatment, Zolpidem (Ambien).

**Decision rationale:** Ambien (zolpidem) is a non-benzodiazepine gamma-aminobutyric acid (GABA) agonist used for the short-term treatment of insomnia. The Medical Treatment Utilization Schedule (MTUS) does not specifically address zolpidem. The ODG state that treatment of insomnia should be through correction of underlying deficits. They further note that zolpidem is indicated for short-term treatment of insomnia. They note that zolpidem has multiple side effects and adults who use zolpidem have a greater than 3-fold increased risk for early death

(Kripke, 2012). Likewise, the FDA has recommended lower doses for IR release products in women (10 mg to 5 mg) and a decrease from 12.5 mg to 6.25 mg for extended-release products (Ambien CR). In this case, Ambien has been used beyond the short-term; likewise, at greater than recommended doses. Therefore, the record does not document the medical necessity for Ambien.

**VIIBRYD 40MG:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Mental Illness & Stress.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Mental Illness & Stress, Antidepressants; Antidepressants for Treatment of MDD.

**Decision rationale:** Viibryd (vilazodone) is a type of SSRI class antidepressant (serotonergic agonist). The California Medical Treatment Utilization Schedule (MTUS) does not address depression. The Official Disability Guidelines (ODG) state that cognitive and behavioral therapy are recommended and are standard treatment for mild presentation of major depressive disorders. They may be used in combination with antidepressant medications or alone. The Guidelines further note that antidepressants are recommended, although generally not as stand-alone treatment. They are recommended for initial treatment of major depressive disorders that are moderate, severe, or psychotic. They state that antidepressants offer significant benefit in the treatment of the severest depressive symptoms, but may have little or no therapeutic benefit over and above placebo in patients with mild to moderate depression. In this case, the record notes that the patient has major depression. The non-certification was an adjustment in the quantity of the medication to #30. The RFA does not request a specific quantity. Therefore, there is no documentation for the medical necessity for an unspecified quantity of Viibryd.

**TRAZODONE 100MG #60:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Mental Illness & Stress.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation : ODG, Mental Illness & Stress, Antidepressants; Antidepressants for Treatment of MDD, as well as information from Uptodate: Unipolar Minor Depression in Adults: Management & Treatment.

**Decision rationale:** Trazodone is an SSRI class antidepressant. The California Medical Treatment Utilization Schedule (MTUS) does not address depression. The Official Disability Guidelines (ODG) state that cognitive and behavioral therapy are recommended and are standard treatment for mild presentation of major depressive disorders. They may be used in combination with antidepressant medications or alone. The Guidelines further note that antidepressants are recommended, although generally not as stand-alone treatment. They are recommended for initial treatment of major depressive disorders that are moderate, severe, or psychotic. They state

that antidepressants offer significant benefit in the treatment of the severest depressive symptoms, but may have little or no therapeutic benefit over and above placebo in patients with mild to moderate depression. Authoritative sources such as UpToDate state that treatment of minor depression with antidepressant medication monotherapy is generally not recommended. There appears to be no absolute advantage of the reuptake inhibitors versus tricyclic antidepressants. In this case, the record notes that the patient has major depression. The non-certification was not for the drug, but rather the additional 2 refills. In this case, long-term treatment of the claimant with Trazodone for major depression with insomnia is appropriate. Therefore, there is documentation for the medical necessity of Trazodone with refills as requested.