

Case Number:	CM13-0009586		
Date Assigned:	09/17/2013	Date of Injury:	05/13/2002
Decision Date:	01/30/2014	UR Denial Date:	07/10/2013
Priority:	Standard	Application Received:	08/12/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Sports Medicine and is licensed to practice in New York and Texas. 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 physician 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:

The patient is a 42-year-old female who reported an injury on 05/13/2002. The patient is currently diagnosed with depressive disorder, pain disorder, psychological factors and opioid dependence. The patient was recently seen by [REDACTED] on 08/12/2013. The patient presented with complaints of acute anxiety and depression. Examination revealed an anxious mood and tearfulness. Treatment recommendations included the continuation of current medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg, one tab every 4 hours #180 as needed for breakthrough pain, two months refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Baseline pain and functional assessment should be made. Ongoing review and documentation of pain relief,

functional status, appropriate medication use and side effects should occur. As per the clinical notes submitted, there is no indication from the available documentation of any significant objective functional improvement that has occurred from the use of an opioid pain medication. A satisfactory response to treatment has not been indicated by a decrease in pain level, increase in functional level or improved quality of life. Therefore, continuation cannot be determined as medically appropriate. As such, the request is non-certified.

Request for prescription of Amitriptyline 25mg every night #30 for insomnia, two months refill: Upheld

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

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

Decision rationale: The California MTUS Guidelines state that antidepressants are recommended as a first-line option for neuropathic pain and as a possibility for nonneuropathic pain. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated or are contraindicated. Assessment of treatment efficacy should include not only pain outcomes but also an evaluation of function, changes in the use of other analgesic medications, sleep quality and duration and psychological assessment. Amitriptyline is indicated for neuropathic pain. As per the clinical notes submitted, there is no evidence of neuropathic pain. There was also no documentation of objective functional improvement that has occurred from the use of this medication. As such, the ongoing use cannot be determined as medically appropriate. Therefore, the request is non-certified.

Request for prescription of for Voltaren Gel, four times a day to left trochanteric bursitis (unspecified quantity): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: The California MTUS Guidelines state that topical analgesics are largely experimental in use, with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Topical NSAIDs are recommended for short-term use for up to 4 to 12 weeks. The only FDA-approved topical NSAID is diclofenac, or Voltaren gel, which is indicated for the relief of osteoarthritis pain. As per the clinical notes submitted, the patient does not maintain a diagnosis of osteoarthritis. There was also no evidence of a failure to respond to first-line oral medications prior to the initiation of a topical analgesic. Therefore, the ongoing use cannot be determined as medically appropriate. As such, the request is non-certified.

Request for prescription of Lunesta 2mg, two tablets every night for insomnia, two months refill: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain (updated 06/07/13)

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 state that insomnia treatment is recommended based on etiology. Lunesta has demonstrated reduced sleep latency and sleep maintenance. Empirically supported treatment includes stimulus control, progressive muscle relaxation and paradoxical intention. As per the clinical notes submitted, the patient has continuously utilized this medication. There is no indication of objective measurable improvement that has occurred from the use of this medication. Long-term use of sleeping agents is not supported in the guideline criteria. There is also no documentation of a failure to respond to nonpharmacological treatment prior to the initiation of a prescription medication. Based on the clinical information review, the request is non-certified.