MAXIMUS Federal Services

Case Number:	CM13-0023506		
Date Assigned:	11/15/2013	Date of Injury:	09/09/2005
Decision Date:	01/07/2014	UR Denial Date:	09/03/2013
Priority:	Standard	Application Received:	09/12/2013

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 and Rehabilitation and is licensed to practice in California. 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.

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 61-year-old male who reported a work-related injury on 09/19/2005. He is status post left knee surgery for full meniscus tear. MRI of the left knee revealed some medial tibial plateau rim attritional changes/diminution of his chondral surfaces and some underlying, medial greater than lateral, tibial rim bone edema. The patient complains of bilateral knee pain. The patient wears a knee brace on his right knee. The patient's medications include Lunesta, Lyrica, Cymbalta, Lidoderm patch, Lexapro, Terazosin, Prevacid, methadone, Dilaudid, Nuvigil, Zofran, Senokot S, Senna, Androderm, AeroChamber Z STAT, albuterol, bupropion HCl, ipratropium-albuterol, and hydromorphone. The patient underwent a cortisone injection to the left knee in 10/2012.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nuvigil 250 mg tab #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Armodafinil..

Decision rationale: The clinical note dated 07/18/2013 stated the patient noted bilateral knee pain and his were unchanged since the last visit. He reported another fall, which hurt his left

knee and his symptoms were improved with ice. Objective findings revealed the patient Final Determination Letter for IMR Case Number CM13-0023506 3 appeared to be depressed, in moderate pain, and tearful. The patient had an awkward, slow, and unsteady gait and was assisted by crutches and a right unloader knee brace. Physical exam of the right knee noted swelling to the knee joint and range of motion was restricted. Tenderness to palpation was noted over the lateral joint line and medial joint line with mild effusion in the right knee joint. Exam of the left knee noted tenderness to palpation over the medial joint line with no joint effusion noted. There was a negative Lachman's test and negative varus/valgus stress. The patient's medications included Terazosin, Lunesta, Cymbalta, methadone, Dilaudid, Lyrica, Nuvigil, Senokot Lidoderm patch, Lexapro, Prevacid, and Zofran. It was noted the patient was taking Nuvigil for excessive sleepiness. The clinical note dated 08/19/2013 stated the patient presented with bilateral knee pain that he rated as an 8 on a scale of 1 to 10. The patient reported another fall, which caused him to knock out his left upper front temporary tooth. He reported poor quality of sleep and his activity level had remained the same. The patient stated that his medications were working well and side effects from medications were noted as constipation, nausea, chills/hot flashes, dry mouth, and sweating. The clinical note dated 09/16/2013 stated the patient's pain level had remained unchanged since the last visit. The patient's quality of sleep was poor and his activity level had remained the same. It was noted the patient's current medication regimen was working well, allowing the patient to perform ADLs and allows activities to be moderately tolerable. The patient's Dilaudid had been reduced from 6 to 5 every day and his Lyrica had been reduced to 400 mg per day from 600 mg per day and the patient continued to attempt to taper medications as much as possible. Official Disability Guidelines indicate Nuvigil is not recommended solely to counteract sedation effects of narcotics. Armodafinil is used to treat excessive sleepiness caused by narcolepsy or shift work sleep disorder. The clinical documentation presented for review stated the patient was prescribed Nuvigil for excessive sleepiness, yet it did not state what the sleepiness was caused from. The patient was noted to complain of poor quality of sleep. Per the submitted documentation, the reason for taking Nuvigil was not clear and there were no subjective or objective findings submitted to warrant the use of Nuvigil in the patient. Therefore, the request for Nuvigil 250 mg tab #30 is non-certified.