

<b>Case Number:</b>	CM13-0025893		
<b>Date Assigned:</b>	11/20/2013	<b>Date of Injury:</b>	02/25/2010
<b>Decision Date:</b>	02/11/2014	<b>UR Denial Date:</b>	09/05/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2013

### 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 Pain Management, has a subspecialty in Disability Evaluation 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. 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 is a 39 year-old male s/p injury 11/14/11. According to medical report dated August 26, 2013, the claimant was initially evaluated by [REDACTED], on July 6, 2011 with his of orthopedic injuries, sustained over several years of working. She experienced constant pain in her right wrist and arm. She had abdominal pain and headaches and became chronically fatigued. As her condition failed to improve, she experienced daily anxiety and depression. She developed sleep disturbance, and her libido diminished. She noticed changes in her social interactions with family members, friends and coworkers. She had less interest in activities of daily living and recreation. These symptoms have persisted. The criteria for diagnoses of Adjustment Disorder with Mixed Anxiety and Depressed Mood, Chronic; Insomnia-Type Sleep Disorder Due to Pain; and Female Hypoactive Sexual Desire Disorder due to Pain. We noted our impressions of psychological factors affecting some of her medical conditions and a Pain Disorder associated with her orthopedic condition. We rated her GAF at 50. We recommended a course of eight sessions of individual psychotherapy and an evaluation with a psychiatrist to determine whether the use of psychotropic medications was indicated. In another medical report from [REDACTED] the claimant was seen again on April 30, 2012 at that time, she was found that she had reached the point of maximal medical improvement, with a disability rating of slight to slight to moderate, according to workers' Compensation guidelines. This corresponds to a GAF of 57 and a WPI of 20 and no basis for apportionment to nonindustrial factors. She had participated in a course of individual psychotherapy with [REDACTED] staff psychotherapist, but did not participate consistently. She was consulting [REDACTED] staff psychiatrist; once a month, for Prescription and monitoring of cymbalta, Ativan, and Atarax. [REDACTED] started her on Ambien in April 2012- to w

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Zolpidem ER:** Upheld

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

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

**Decision rationale:** The California MTUS is mute on Zolpidem therapy. The Official Disability Guidelines (ODG) regarding Zolpidem (Ambien) for chronic pain: Zolpidem -is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term treatment of insomnia: Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers: There is also concern that they may increase pain and depression over the long-term. According to Medline Plus, Zolpidem is used to treat insomnia (difficulty falling asleep or staying asleep) and it belongs to a class of medications called sedative-hypnotics. It works by slowing activity in the brain to allow sleep. Zolpidem should normally be taken for short periods of time (less than two weeks). If Zolpidem is taken for 2 weeks or longer, it may not help a patient sleep as well as it did when the patient first began to take the medication. Therefore Zolpidem ER is not medically necessary.

### **Lorazepam:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepine Section Page(s): 24.

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

**Decision rationale:** According to Chronic Pain Medical Treatment guideline (MTUS effective July 18 2009), page 24 of 127, Ativan (a class of benzodiazepine) is 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. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. (Baillargeon, 2003) (Ashton 2005). It appears that this patient may have been using this medication chronically since 1/11/2012.y. MTUS guidelines do not support use of benzodiazepines on a chronic basis although they do support short -term use

for anxiety. If this patient has been taking this medication regularly then is likely that both tolerance and dependence have developed. Rapid cessation of this medication could be harmful to the patient. The last UR physician recommended a short-term approval of up to 30 tablets for weaning purposes. Medical report from the prescribing physician was not available to review, and there is no documentation of any functional improvement with respect to all the medication being prescribed hence the request for Lorazepam is not medically necessary.

**Cymbalta:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cymbalta Section Page(s): 15-16.

**Decision rationale:** The California MTUS (Effective July 18, 2009) page 15 to 16 of 127 indicated that Duloxetine (Cymbalta®) is FDA-approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. Used off-label for neuropathic pain and radiculopathy. Duloxetine is recommended as a first-line option for diabetic neuropathy. (Dworkin, 2007) No high quality evidence is reported to support the use of duloxetine for lumbar radiculopathy. (Dworkin, 2007) More studies are needed to determine the efficacy of duloxetine for other types of neuropathic pain. Side effects: CNS: dizziness, fatigue, somnolence, drowsiness, anxiety (3% vs.2% for placebo), insomnia (8-13% vs. 6-7% for placebo). GI: nausea and vomiting (5-30%), weight loss (2%). Duloxetine can worsen diabetic control in some patients. It also causes sexual dysfunction. (Maizels, 2005) Dosing: 60 mg once a day as an off-label option for chronic pain syndromes. Dosage adjustment may be required in patients with renal insufficiency. Venlafaxine (Effexor®): FDA-approved for anxiety, depression, panic disorder and social phobias. Off-label use for fibromyalgia, neuropathic pain, and diabetic neuropathy. Side-effect profile: CNS: (5%) drowsiness, weakness, dizziness, dry mouth, insomnia, nervousness/anxiety (13/6% vs. 6/3%), tremor, headache, seizures. GI: N&V, constipation, weight loss (2-18%). Pre-existing hypertension should be controlled. Cholesterol may be increased (5%). Sexual dysfunction has also been noted. (Maizels, 2005) (ICSI, 2007) Dosing: Neuropathic pain (off-label indication): 37.5 mg once daily, increase by 37.5 mg per week up to 300 mg daily. (Maizels, 2005) (ICSI, 2007) Trial period: Some relief may occur in first two weeks; full benefit may not occur until six weeks. Withdrawal effects can be severe. Abrupt discontinuation should be avoided and tapering is recommended before discontinuation. According to the medical record of ██████████, the claimant was prescribed Cymbalta 30 mg daily for anxiety and depression, however, the agreed medical examiner ██████████, in his supplemental report stated: This examiner respectfully disagrees with the opinions rendered by ██████████. ██████████ does not have an accurate, detailed history of the patient's longstanding preindustrial difficulties. He does not seem to be aware of the patient's panic attacks, her long and many years of agoraphobia. She does not suffer from major depressive illness. Presently the claimant is reporting feeling wonderful, capable, and fully able to do her job. Cymbalta is an antidepressant, and it appears the patient has been using this previously as it has been requested before by ██████████. There is no mention of the dose, instructions for use or quantity being currently being prescribed. There is no mention of whether or not the patient has had functional improvement as a result of use of the Cymbalta. Since rapid

cessation of this medication could cause harm to the patient up to a 30 day supply was considered to be medica

**Orthopedic treatment:** Overturned

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 3rd Edition, (2011) Chapter 7, Section on Independent Medical Examination and Consultation.

**Decision rationale:** The California MTUS (Effective July 18, 2009) ACOEM Guidelines, 3rd Edition, 2011 chapter 7, regarding independent medical examination and consultation, "If a diagnosis is uncertain or complex, if psychosocial factors are present or if the plan or course of care may benefit from additional expertise, the occupational health physician may refer a patient to other specialists for an independent medical assessment. There are two types of these examination referrals- the consultation and the independent medical examination (IME). A consultation is intended to aid in assessing the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or examinee's fitness for return to work. A consultant is usually requested to act in an advisory capacity, however, may sometimes take full responsibility for investigating and/or treating a patient within the doctor-patient relationship." PTP progress report of 9/10/13 [PA-C]: a. Subjective: Persistent pain (R) shoulder. Still attending postop PT and following up with operating surgeon. Tramadol helps. He rather take this and Vicodin. Symptomatology essentially unchanged in cervical spine, (B) hands/wrists, lumbar, (B) feet. b. Objective: Cervical spine: exam essentially unchanged; continued symptomatology with paravertebral spasm; +axial loading compression test with extension of symptomatology in upper extremities. (R) shoulder: well-healed scar; atrophy; limited ROM, weakness. (B) hands/wrists: exam essentially unchanged; +palmar compression test subsequent to Phalen's; reproducible symptomatology with + Tinel's in median nerve distribution consistent with carpal tunnel syndrome; double crush syndrome has been established. Lumbar: exam essentially unchanged; tenderness paravertebral muscles; pain with terminal motion; +seated nerve root test. (B) feet: exam essentially unchanged; pain, tenderness in heel cord, plantar soles, aspects of feet consistent with plantar fasciitis; no gross or obvious signs of cutaneous eruptions and/or skin infections noted. c. Diagnosis: Cervical discopathy. Lumbar discopathy/segmental instability. S/p (R) shoulder replacement 8/16/13. (B) carpal tunnel syndrome/double crush syndrome. (B) plantar fasciitis. d. Plan: i. Continue to follow up with surgeon and continue post-op ROM per surgeon ii. Can take appropriate pharmacological agents for symptomatic relief. Medications requested under separate cover/report. e. RTC 6 weeks. Therefore the request for continued orthopedic treatment is medically necessary, based on the above medical report.

**Psychiatric treatment (QTY 3):** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 3rd Edition, (2011) Chapter 7, Section on Independent Medical Examination and Consultation.

**Decision rationale:** The California MTUS (Effective July 18, 2009) ACOEM Guidelines, 3rd Edition, 2011 chapter 7, regarding independent medical examination and consultation, "If a diagnosis is uncertain or complex, if psychosocial factors are present or if the plan or course of care may benefit from additional expertise, the occupational health physician may refer a patient to other specialists for an independent medical assessment. There are two types of these examination referrals- the consultation and the independent medical examination (IME). A consultation is intended to aid in assessing the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or examinee's fitness for return to work. A consultant is usually requested to act in an advisory capacity, however, may sometimes take full responsibility for investigating and/or treating a patient within the doctor-patient relationship." There was received a progress dated 8/1/12 from a different psychiatrist [REDACTED] that stated the patient was anxious depressed and had difficulty sleeping. There were no objective findings. This report stated that the medical services will be provided by [REDACTED] and that Cymbalta, Ativan and Ambien CR would be the patient's medications. All though the UR physician approved a psychiatric re-evaluation, there was no medical report from [REDACTED], the treating psychiatrist. Therefore the request for continued psychiatric treatment is not medically necessary.