

Case Number:	CM13-0027149		
Date Assigned:	12/18/2013	Date of Injury:	06/08/2000
Decision Date:	07/24/2014	UR Denial Date:	08/22/2013
Priority:	Standard	Application Received:	09/19/2013

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 Medicine 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 72-year-old with a date of injury of June 8, 2000. A progress report associated with the request for services, dated July 1, 2013, was correlated with an explanation letter dated July 5, 2013, which identified subjective complaints of depression, anxiety, and agitation due to pain. Objective findings were not documented. Diagnoses included depressive disorder with anxiety; and a psychological disorder affecting a medical condition. Treatment has included oral analgesics and antidepressants. A Utilization Review determination was rendered on August 22, 2013 recommending non-certification of "retrospective request for one prescription of hydrocodone/acetaminophen 10/325mg, #60 (dos: July 16, 2013); retrospective request for 1 prescription of estazolam 2mg, #30 (dos: July 16, 2013); retrospective request for 1 prescription of hydroxyzine HCl 25mg, #60(dos: July 16, 2013); and retrospective request for 1 prescription of sertraline HCl 100mg, #60 (dos: July 16, 2013)".

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for one prescription of hydrocodone/acetaminophen 10/325mg, sixty count provided on July 16, 2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Opioids for Chronic Pain.

Decision rationale: Norco 10/325 is a combination drug containing acetaminophen and the opioid hydrocodone. The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Guidelines related to on-going treatment of opioids state that there should be documentation and ongoing review of pain relief, functional status, appropriate use, and side effects. The guidelines note that a recent epidemiologic study found that opioid treatment for chronic non-malignant pain did not seem to fulfill any of the key outcome goals including pain relief, improved quality of life, and/or improved functional capacity (Eriksen 2006). The Chronic Pain Guidelines also state that with chronic low back pain, opioid therapy "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (> 16 weeks), but also appears limited." The patient has been on Norco in excess of 16 weeks. The Official Disability Guidelines (ODG) state: "While long-term opioid therapy may benefit some patients with severe suffering that has been refractory to other medical and psychological treatments, it is not generally effective achieving the original goals of complete pain relief and functional restoration." Therapy with Norco appears to be ongoing. The documentation submitted lacked a number of the elements listed above, including the level of functional improvement afforded by the chronic opioid therapy. Therefore, the retrospective request for one prescription of hydrocodone/acetaminophen 10/325mg, sixty count provided on July 16, 2013, is not medically necessary or appropriate.

Retrospective request for one prescription of Estazolam 2mg, thirty count provided on July 16, 2013: Upheld

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

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

Decision rationale: Estazolam (Eurodin) is a benzodiazepine derivative 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 retrospective request for one prescription of Estazolam 2mg, thirty count provided on July 16, 2013, is not medically necessary or appropriate.

Retrospective request for one prescription of hydroxyzine HCL 25mg, sixty count provided on July 16, 2013: 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, Insomnia.

Decision rationale: Hydroxyzine (Vistaril) is an antihistamine used for treatment of insomnia. Pharmacologic therapy for insomnia should include documentation of sleep onset, sleep maintenance, and sleep quality and next-day functioning. Specifically, the Official Disability Guidelines note that: "Sedating antihistamines have been suggested for sleep aids (for example diphenhydramine). Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. Side effects include urinary retention, blurred vision, orthostatic hypotension, dizziness, palpitations, increased liver enzymes, drowsiness, dizziness, grogginess and tiredness." In this case, the above noted documentation was not available. Also, the already achieved short-term benefits and potential side effects associated with ongoing therapy do not support medical necessity. The retrospective request for one prescription of hydroxyzine HCL 25mg, sixty count, provided on July 16, 2013, is not medically necessary or appropriate.

Retrospective request for one prescription of Sertaline HCL 100mg, sixty count provided on July 16, 2013: 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) Mental Illness & Stress, Antidepressants; Antidepressants for Treatment of MDD Other Medical Treatment Guideline or Medical Evidence: UpToDate: Unipolar minor depression in adults: Management and treatment.

Decision rationale: Zoloft (sertraline) 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. The non-certification was based upon insufficient documentation for the use of the requested medication. The record does not specify the type of depression and there is no documentation of major depression. Therefore, the retrospective request for one prescription of Sertaline HCL 100mg, thirty count provided on July 16, 2013, is not medically necessary or appropriate.

