

Case Number:	CM13-0028698		
Date Assigned:	11/27/2013	Date of Injury:	02/07/2000
Decision Date:	03/26/2014	UR Denial Date:	08/28/2013
Priority:	Standard	Application Received:	09/24/2013

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 Family Medicine and is licensed to practice in Arizona. He/she has been in active clinical practice for more than five years and is currently working least at 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:

Patient is a 54 year old female with a date of injury of 2/7/2000. Patient has been receiving on-going treatment for psychiatric concerns, and symptoms in the left shoulder, right knee, lumbar spine, and right ankle. Diagnoses include lumbar radiculopathy, lumbar spine chronic pain, and shoulder pain. Medications include Norco, Flexeril, Protonix, Effexor and Motrin. Subjective complaints are constant low back pain with radiation to her right leg, with occasional tingling, and left shoulder pain. Pain is rated at 6-8/10 in the lower back that is aggravated by activities. Pain in shoulder is sporadic and rated at 4-7/10. Physical exam shows decreased lumbar range of motion, tenderness at L4-S1 spinous processes, tenderness of right paraspinals and sacroiliac joint, strength and sensation in the bilateral lower extremities was normal. Shoulder exam reveals tenderness over trapezius and deltoid, without weakness or decreased sensation. Patient has had prior treatment with chiropractic, physical therapy, and medications. Submitted medical records did not include evidence of psychiatric consultation, or any discussion of her insomnia, excessive daytime sleepiness, or depression.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective medication request for 8 prescriptions of Zolpidem Tartrate 10 mg, #30:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic).

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

Decision rationale: ODG suggests that Zolpidem is only approved for the short-term treatment of insomnia. The recommended time-frame of usage is usually 2 to 6 weeks and long-term use is rarely recommended. Sleeping pills can be habit-forming, impair function and memory, and increase pain and depression over long-term use. For this patient the request for 8 prescriptions of 30 pills would place the treatment time well over 6 weeks. Therefore, continuation of this medication exceeds recommended usage per guidelines, and is not a medical necessity.

Retrospective medication request for 2 prescriptions of Nuvigil 150 mg, #30: 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 Guidelines (ODG) PAIN, ARMODAFINIL.

Decision rationale: ODG does not recommend the medication to counteract the sedation effects of narcotics. The medication is only approved to treat excessive sleepiness caused by narcolepsy or shift work sleep disorder. The submitted documentation does not identify excessive sleepiness or narcolepsy. Therefore, the medical necessity of Nuvigil is not established.

Retrospective medication request for 8 prescriptions of Venlafaxine HCL 75 mg, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIDEPRESSANTS FOR CHRONIC PAIN Page(s): 14.

Decision rationale: CA MTUS and ODG recommend the use of venlafaxine as a treatment for chronic pain especially if pain is accompanied by insomnia, anxiety, or depression. CA MTUS acknowledge that specifically for lumbar radiculopathy, there are no high quality studies that demonstrate efficacy. This patient has undergone long-term treatment with venlafaxine, yet is without documentation of significant pain reduction or functional improvement. Therefore the medical necessity of further treatment is not established.

Retrospective medication request for 8 prescriptions of Ranitidine HCL 150 mg, #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation the New Zealand Guidelines Group (NZG), Management of dyspepsia and heartburn. Wellington (NZ): New Zealand Guidelines Group (NZG); 2004 Jun. 119 p. {333 references.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

Decision rationale: CA MTUS guidelines state that PPI's (Proton Pump Inhibitors) or H2 receptor antagonists can be used in the treatment of dyspepsia secondary to NSAID therapy. The submitted medical records do not indicate any ongoing dyspepsia, and does not document any significant functional improvement or relief of symptoms with this medication. Therefore the medical necessity of this medication is not established.

retrospective medication request for 7 prescriptions of Hydroxyzine HCL 25 mg, #60:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PAIN, ANXIETY MEDICATIONS IN CHRONIC PAIN

Decision rationale: ODG suggests that hydroxyzine can be utilized in the management of anxiety in chronic pain. The submitted documentation does not mention the rationale or indication for using this medication, especially in conjunction with other previously prescribed anxiety medications. Also brief reference is made in prior utilization review that previous hydroxyzine did not work per 10/6/2006 report. Therefore, the medical necessity of this medication is not established.

Retrospective medication request for 3 prescriptions of Carisoprodol 350 mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CARISOPRODOL Page(s): 29.

Decision rationale: CA MTUS does not recommend carisoprodol. This medication is not indicated for long-term use. This medication is only recommended for a 2-3 week period. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. This patient has used carisoprodol consistently for years, which is not consistent with current guidelines. For these reasons, the use of carisoprodol is not medically necessary.

