

Case Number:	CM13-0036151		
Date Assigned:	12/13/2013	Date of Injury:	04/17/2012
Decision Date:	05/15/2014	UR Denial Date:	10/08/2013
Priority:	Standard	Application Received:	10/18/2013

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 Physical Medicine and Rehabilitation, and is licensed to practice in Illinois. 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:

The injured worker is a 54-year-old who reported an injury on 4/17/02. The mechanism of injury was not provided for review. The injured worker sustained injuries to her back, left hip, and bilateral lower extremities. The injured worker's chronic symptoms were controlled with medications. The injured worker was monitored for aberrant behavior with urine drug screens. The injured worker was evaluated on 8/9/13. The injured worker's physical exam findings included restricted lumbar range of motion secondary to pain and spring testing non-contributory to sacroiliac pain. The injured worker's diagnoses included lumbar spinal stenosis, lumbar and sacral osteoarthritis, chronic pain, lumbosacral radiculopathy, and facet syndrome. The injured worker's medication schedule included Gabapentin, Lunesta, Lidoderm patches, Norco, Omeprazole, Paxil, Desyrel, Zanaflex, and pantoprazole. A request was made for a refill of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

90 NORCO 10/325MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

Decision rationale: The California MTUS recommends the continued use of opioids be supported by documentation of functional benefit, a quantitative assessment of pain relief, evidence that the injured worker is monitored for aberrant behavior, and managed side effects. The clinical documentation submitted for review indicates that the injured worker has been on this medication since at least November 2012. Although there is documentation that the injured worker is monitored for aberrant behavior, there is no evidence of significant pain relief or functional benefit to support continued use of this medication. As such, the requested Norco is not medically necessary or appropriate.

30 PAROXETINE (PAXIL) 20MG WITH TWO REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 377-378.

Decision rationale: The ACOEM recommends the short-term use of antidepressants in the management of stress-related pain. The clinical documentation submitted for review indicates that the injured worker has been on this medication for a significant period of time. As there is no documentation of functional benefit or pain relief related to this medication, continued use would not be supported. Additionally, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Paroxetine (Paxil) is not medically necessary or appropriate.

90 TIZANIDINE (ZANAFLEX) 4MG WITH FIVE REFILLS:

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

Decision rationale: The California MTUS does not support the use of muscle relaxants in the management of chronic pain. The California MTUS recommends that the use of muscle relaxants be reserved for short durations of treatment not to exceed 2-4 weeks for acute exacerbations of chronic pain. The clinical documentation submitted for review indicates that the injured worker has been on this medication for an extended time period. Additionally, the request as it is submitted is for a duration of time that exceeds guideline recommendation usage. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. Additionally, there is no documentation of functional benefit or symptom relief related to the use of this medication. Also, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request as it is submitted itself cannot be determined. As such, the requested Tizanidine (Zanaflex) is not medically necessary or appropriate.

30 PANTOPROZOLE 20MG:

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: The California MTUS recommends the ongoing use of gastrointestinal protectants for injured workers who have risk factors of gastrointestinal disturbances resulting from medication usage. The clinical documentation submitted for review does not provide a recent adequate assessment of the injured worker's risk factors to support the need for a gastrointestinal protectant. As such, the requested pantoprazole is not medically necessary or appropriate.

30 ZOLPIDEM (AMBIEN) 5MG: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

Decision rationale: The California MTUS does not address this medication. The Official Disability Guidelines recommend a short duration of treatment for this medication to assist in the restoration of sleep patterns for injured workers with insomnia related to chronic pain. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's sleep hygiene to support the need for pharmacological intervention. Additionally, the injured worker's treatment history indicates that the injured worker has been on this medication for an extended duration. Therefore, continued use of this medication would not be supported. Also, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Zolpidem (Ambien) is not medically necessary or appropriate.

30 VENLAFAXINE (EFFEXOR) 37.5MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 387-388, Chronic Pain Treatment Guidelines Page(s): 13.

Decision rationale: The ACOEM recommends the short-term use of antidepressants in the management of stress-related pain. The clinical documentation submitted for review does indicate that the injured worker has been on this medication for a significant period of time. As

there is no documentation of functional benefit or pain relief related to this medication, continued use would not be supported. Additionally, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Venlafaxine (Effexor) is not medically necessary or appropriate.

60 MIRTAZAPINE (REMERON) 15MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 387-388, Chronic Pain Treatment Guidelines Page(s): 13.

Decision rationale: The ACOEM recommends the short-term use of antidepressants in the management of stress-related pain. The clinical documentation submitted for review does indicate that the injured worker has been on this medication for a significant period of time. As there is no documentation of functional benefit or pain relief related to this medication, continued use would not be supported. Additionally, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Mirtazapine (Remeron) is not medically necessary or appropriate.