

Case Number:	CM13-0046727		
Date Assigned:	12/27/2013	Date of Injury:	12/15/1989
Decision Date:	03/19/2014	UR Denial Date:	10/19/2013
Priority:	Standard	Application Received:	11/01/2013

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:

The patient is a 57 year old injured worker with a date of injury of 12/15/1989 and status post 11 back surgeries including bilateral SI joint fusion on 8/11/2013. On 10/10/13, the patient stated that his medications were cut off and he hadn't slept since 9/16/13 due to lack of sleep and worsening back pain. With ongoing bilateral legs, buttocks, thoracic spine, bilateral hips, bilateral low back, and groin pain, he was only able to exercise by walking about 300 yards 6 days a week. Current medications improved pain from 9-10/10 to 6-10/10. Per the treating physician notes, OxyContin reduces pain 90% to become functional, get out of bed and walk, thus would like to decrease morphine sulfate from 6 to 4 per day; Carisoprodol decreases spasms 70% and he wants to decrease from 3 to 2/day; Lyrica helps decrease neuropathic pain 75%; Sonata helps with sleep 100%, and Restoril helps continued sleep throughout night; Seroquel helps with depression and sleep; Lexapro and Wellbutrin help decrease depression; Colace helps decrease constipation 100%. Upon examination, the patient ambulated with slow, steady gait. Current diagnosis were chronic pain syndrome, postlaminectomy, lumbar, lumbar back pain with bilateral radiculopathy, sacroiliac joint dysfunction, myofascial pain syndrome, chronic depression, chronic anxiety, chronic insomnia, status post arthrodesis, anterior and posterior, lumbar L3-4, L4-5, L5-S1, degenerative disc disease lumbar spine, and testicular pain. ■■■■■ has requested continued use of all medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Seroquel 200 mg #30 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 388.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Decision rationale: Seroquel is a psychotropic medication used to treat schizophrenia, major depression, and bipolar disorder. In general, the Chronic Pain Medical Treatment Guidelines recommend anti-depressants for the treatment of chronic pain, neuropathic pain and secondary depression. According to the Official Disability Guidelines (ODG) "Atypical Anti-psychotics Not recommended as a first-line treatment. There is insufficient evidence to recommend atypical antipsychotics (eg, quetiapine, risperidone) for conditions covered in ODG". The request for 1 prescription of Seroquel 200 mg #30 with 1 refill is not medically necessary and appropriate.

1 prescription of Restoril 30 mg #30 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) -TWC-Pain (Chronic)

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines recommended antidepressants as the most appropriate treatment for anxiety. The Official Disability Guidelines (ODG) does not recommend this medication as the first line treatment in patients with chronic pain. Authorization after a one-month period should include the specific necessity for ongoing use as well as documentation of efficacy. Based on the medical records provided for review there is no documentation of specific need and the efficacy of previous treatment. The request for 1 prescription of Restoril 30 mg #30 with 1 refill is not medically necessary and appropriate.

Sonata 20 mg #30 with 1 refill: Upheld

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

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

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines does not support use of this medication of more than two weeks and the continuous of this medication would not be supported. According to the Official Disability Guidelines (ODG),"Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness.

(Lexi-Comp, 2008). The request for Sonata 20 mg #30 with 1 refill is not medically necessary and appropriate.

Xanax XR 3mg #60 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiaepine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Chronic Pain

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines does not support a long term use of this medication. Most guideline limit is 4 weeks. The Official Disability Guidelines (ODG) does not recommend this medication as the first line treatment in patients with chronic pain. The MTUS Chronic Pain Medical Treatment Guidelines recommended antidepressants as the most appropriate treatment for anxiety. Authorization after a one-month period should include the specific necessity for ongoing use as well as documentation of efficacy. Based on the medical records provided for review there is no documentation of specific need and the efficacy of previous treatment. The request for Xanax XR 3mg #60 with 1 refill is not medically necessary and appropriate.

Morphine Sulfate CR 30 mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiaepine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Chronic Pain, Opioids

Decision rationale: The request for Morphine Sulfate is indicated for once daily administration for the relief of moderate to severe breakthrough pain requiring continuous, around-the-clock opioid therapy for an extended period of time, It is not supported as the first line treatment for Neuropathic pain. The request for Morphine Sulfate CR 30 mg #120 is not medically necessary and appropriate.

Carisoprodol 350 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC-Pain (Chronic), Carisoprodol (Soma®)

Decision rationale: The CA-MTUS Chronic Pain Medical Treatment Guidelines section on Antispasmodics-Carisoprodol (Soma®®, Soprodal 350mg, Vanadom®®, generic available) "Neither of these formulations is recommended for longer than a 2 to 3 week period". According to the Official Disability Guidelines (ODG) "Not recommended. This medication is FDA-approved for symptomatic relief of discomfort associated with acute pain in musculoskeletal conditions as an adjunct to rest and physical therapy". Based on the medical records provided for review the injured worker does not have any evidence of acute myospasm or acute pain or break-through pain for which the use of Soma is indicated. As well Carisoprodol (Soma) is not indicated for long-term use and not recommended for longer than a two to three week period. The request for Carisoprodol 350 mg #60 is not medically necessary and appropriate.