

Case Number:	CM13-0059590		
Date Assigned:	12/30/2013	Date of Injury:	08/24/2004
Decision Date:	05/20/2014	UR Denial Date:	11/19/2013
Priority:	Standard	Application Received:	12/02/2013

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 Occupational Medicine 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 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 patient reported a date of injury of 8/24/2004. The most recent medical report, an internal medicine consultation, dated 6/26/2013, lists subjective complains as continuing pain in the lower back which is aggravated by most activities of normal daily living. Objective findings: Patient was given a full external body exam with all findings normal. One exception was the lower back which revealed some discomfort with change in positions. No CVA tenderness or gross deformities of the lower back were noted. The patient has been treated for her psychological symptoms and sleep disorder through the worker's compensation system. The patient's major depressive disorder had been poorly controlled and in May 2013, her primary treating physician added Seroquel to her drug regimen. Diagnosis: 1. Lower back injury 2. Extended long term use of pain medications and anti-inflammatories 3. Gastroesophageal reflux diseases 4. Psychological disorder. The medical records provided for review document that the patient has been taking the following medications for at least as far back as 10/22/2009. The medical reports provided also note that the patient was prescribed Hydrocodone at least as far back as 10/22/2009. The date of discontinuation of Hydrocodone was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

AMBIEN 10MG #30, 2 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 (ODG), Pain Chapter (Ambien).

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

Decision rationale: The patient has been taking Ambien for extended period of time and was provided with a weaning dose with the previous utilization review decision. The Official Disability Guidelines do not recommend the use of sleeping pills for long-term use. The patient has been taking Ambien for longer than the 2-6 week period recommended by the ODG. The request for Ambien 10mg #30, 2 refills is not medically necessary.

FIORICET #60, 2 REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23.

Decision rationale: Fioricet is a brand name of a combination of butalbital (a barbiturate), acetaminophen and caffeine which is indicated for the treatment of tension headaches, muscle contraction headaches and post-dural puncture headaches. The patient has been provided with a weaning dose by the previous utilization review decision. Barbiturate-containing analgesic agents are not recommended by the MTUS for chronic pain. The patient has been taking Fioricet for extended period of time. The request for Fioricet #60m 2 refills is not medically necessary.

SEROQUEL 25MG #30, 2 REFILLS: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/pro/seroquel.html>.

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

Decision rationale: Seroquel is a short-acting atypical antipsychotic approved for the treatment of schizophrenia, bipolar disorder, and along with an antidepressant to treat major depressive disorder. Seroquel was added to the patient's medication regimen due to poor control of her major depressive disorder. The ACOEM Guidelines state that antidepressant or antipsychotic medication may be prescribed for her major depression or psychosis; however this is best done in conjunction with specialty referral. I am reversing the prior UR decision. The ACOEM Guidelines provide for the use of approved antipsychotics such as Seroquel, which is also approved for major depression, to treat this patient's psychological disorder. The request for Seroquel 25mg #30, 2 refills is medically necessary.

OMEPRAZOLE 20MG #60, 2 REFILLS: Overturned

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: Physicians are asked to evaluate the patient and to determine if the patient is at risk for gastrointestinal events. Criteria used are: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID. There is documentation that the patient has a history of peptic ulcer and GI bleeding, one of the risk factors needed to recommend a proton pump inhibitor. I am reversing the prior UR decision. The request for Omeprazole 20mg #60, 2 refills is medically necessary.

BUSPAR 10MG #60. 2 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 (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 402.

Decision rationale: BuSpar is approved for the short-term relief of anxiety symptoms. The patient has been provided with a weaning dose by the previous utilization review decision. Anxiolytics are not recommended as first-line therapy for stress-related conditions because they can lead to dependence and do not alter stressors or the individual's coping mechanisms. They may be appropriate for brief periods in cases of overwhelming symptoms that interfere with daily functioning or to achieve a brief alleviation of symptoms that allow the patient to recoup emotional or physical resources. The request for BuSpar 10mg #60, 2 refills is not medically necessary.

BUPROPION 100MG #60, 2 REFILLS: Overturned

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

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

Decision rationale: Bupropion, an atypical antidepressant that acts as a norepinephrine and dopamine reuptake inhibitor, is used to treat major depression. The patient carries a diagnosis of

major depression disorder. Antidepressant or antipsychotic medication may be prescribed for major depression or psychosis; however, this is best done in conjunction with specialty referral. The request for bupropion 100mg #60, 2 refills is medically necessary.