MAXIMUS Federal Services

Case Number:	CM14-0007995		
Date Assigned:	02/07/2014	Date of Injury:	01/15/2007
Decision Date:	07/24/2014	UR Denial Date:	12/31/2013
Priority:	Standard	Application Received:	01/21/2014

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 Anesthesiology, has a subspecialty in Pain Management, and is licensed to practice in Tennessee. 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 is a 44-year-old female, who has submitted a claim for chronic pain syndrome, specifically on the left sacroiliac joint associated with an industrial injury date of January 5, 2007.Medical records from 2013 were reviewed, which showed that the patient complained of sacroiliac joint pain on the left. On physical examination of the lumbar spine, lumbar flexion causes maximum pain felt bilaterally and extension milder pain bilaterally. On examination of the thoracic spine, thoracic flexion causes maximal pain bilaterally, and extension milder pain bilaterally. Lumbar extension causes maximal pain, felt more on right than left. Straight leg raise (SLR) of the lumbar spine caused pain at full range sitting in the right.Treatment to date has included Butran patch, Lexapro, MS Contin, Nexium, omeprazole, Soma, trazodone, Tylenol, Cyclogaba Cream and physical therapy (PT).Utilization review from December 31, 2013 denied the request for AMBIEN CR 6.25MG # 20 X 5 REFILLS and LEXAPRO 10MG #60 X 5 REFILLS however, reasons for denial were not made available.

IMR ISSUES, DECISIONS AND RATIONALES

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

AMBIEN CR 6.25MG # 20 X 5 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 (zolpidem tartrate).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Ambien (zolpidem tartrate), and Non-MTUS: Other Medical Treatment Guideline or Medical Evidence: FDA, Ambien.

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), was used instead. ODG states Ambien (zolpidem) is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. In this case, the patient has been on Ambien since September 2013 (3 months to date). Recent records reviewed did not document that the patient complained of insomnia nor had difficulty sleeping. Likewise, the patient was on Ambien for 12 weeks, which is beyond what the guideline suggests. As stated by the FDA, Ambien is approved for short-term use (two to six weeks). There is a risk that, the use of Ambien may be habit-forming, impair function and memory. In addition, the frequency of medication use was non-specific. Therefore, the request for AMBIEN CR 6.25MG # 20 X 5 REFILLS was not medically necessary.

LEXAPRO 10MG #60 X 5 REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2, Antidepressant for Chronic Pain Page(s): 16.

Decision rationale: As stated on page 16 of the CA MTUS Chronic Pain Medical Treatment Guidelines, SSRI's (Lexapro) are controversial based on controlled trials. It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain. More information is needed regarding the role of SSRIs and pain. In this case, the patient has been on Lexapro since February 2013 (10 months to date). However, there is no documentation concerning functional improvement derived from its use. Furthermore, the prescription did not specify the frequency of medication use. Therefore, the request for LEXAPRO 10MG #60 X 5 REFILLS was not medically necessary.

TYLENOL #4 #150 X 3 REFILLS: 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 9792.24.2, Opioids Page(s): 78-80.

Decision rationale: As stated on CA MTUS Chronic Pain Medical Treatment Guidelines page 80, opioids have been suggested for neuropathic pain that has not responded to first-line

recommendations (antidepressants, anticonvulsants). The lowest possible dose should be prescribed to improve pain and function. Page 78 state that ongoing opioid treatment should include monitoring of analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors; these outcomes over time should affect the therapeutic decisions for continuation. In this case, the patient. In this case Tylenol (Codeine with Acetaminophen) was prescribed to the patient since February 2013 (10 months to date). Although there was frequent monitoring of the level of opioids, records reviewed did not show that there was functional improvement on the patient. Furthermore, the frequency of medication use was not clearly stated. Therefore, the request for TYLENOL #4 #150 X 3 REFILLS was not medically necessary.