MAXIMUS Federal Services

Case Number:	CM14-0104724		
Date Assigned:	07/30/2014	Date of Injury:	02/27/2009
Decision Date:	09/15/2014	UR Denial Date:	06/13/2014
Priority:	Standard	Application Received:	07/07/2014

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 and Pain Medicine and is licensed to practice in Florida. 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 49-year-old male who reported injury on 02/27/2009 caused by an unspecified mechanism. The injured worker's treatment history included physical therapy, medications, MRI. The injured worker was evaluated on 05/23/2014 and it was documented the injured worker complained of moderate to severe pain to in the lower back, gluteal area and right knee. The pain was described as an ache. Symptoms are aggravated by ascending stairs, bending, changing positions, daily activities and descending stairs. Symptoms are relieved by heat, massage and pain medications. Pain without medication, the injured worker reported, was at 8/10 and with medications the pain was rated at 6/10. The provider noted the injured worker stated he is able to do simple chores around the house with medications. Physical examination revealed negative for joint pain, joint swelling, muscle weakness and neck pain. Physical examination of the lumbar spine revealed decreased active range of motion with limiting factors of pain. Rotation was full. Medications included omeprazole 20 mg, Norco 10/325 mg, trazodone 100 mg, Lunesta 3 mg, trazodone 150 mg and MiraLAX oral powder. The gastrointestinal physical examination revealed positive abdominal pain, negative for blood in stool, change in stool pattern, constipation, decreased appetite, diarrhea, heartburn, and nausea and vomiting. The diagnoses include COAT, sleep disturbances, depression/anxiety, muscle spasms, heartburn and chronic pain syndrome. The Request for Authorization dated 05/23/2014 was for omeprazole, trazodone, Lunesta and Norco. However, the rationale was not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole #60 refill:1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton pump inhibitors Page(s): 68-69.

Decision rationale: The request is not medically necessary. Prilosec is recommended for patients taking NSAIDs who are at risk of gastrointestinal events. The documentation submitted did indicate the injured worker having gastrointestinal events however, it was not clear if it was from medications. The provider failed to indicate the frequency, dosage and quantity medication on the request that was submitted. In addition, the provider failed to indicate long term functional goals or medication pain management outcome measurements for the injured worker. Given the above, the request for Omeprazole #60 refill 1 is not medically necessary.

Trazodone HCL #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Treatment Index, 11th edition, (web), 2013, Pain and Insomnia treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): 14 & 15.

Decision rationale: The requested is not medically necessary. California (MTUS) Chronic Pain Medical Guidelines recommends Trazodone as a selective serotonin and norepinephrine reuptake inhibitors (SNRIs) and FDA-approved for anxiety, depression, diabetic neuropathy, and Fibromyalgia. Used off-label for neuropathic pain and radiculopathy. Duloxetine is recommended as a first-line option for diabetic neuropathy. No high quality evidence is reported to support the use of duloxetine for lumbar radiculopathy. A systematic review indicated that tricyclic antidepressants have demonstrated a small to moderate effect on chronic low back pain (short-term pain relief), but the effect on function is unclear. This effect appeared to be based on inhibition of norepinephrine reuptake. SSRIs have not been shown to be effective for low back pain (there was not a significant difference between SSRIs and placebo) and SNRIs have not been evaluated for this condition. Reviews that have studied the treatment of low back pain with tricyclic antidepressants found them to be slightly more effective than placebo for the relief of pain. A non-statistically significant improvement was also noted in improvement of functioning. SSRIs do not appear to be beneficial. It is recommended that these outcome measurements should be initiated at one week of treatment with a recommended trial of at least 4 weeks. The provider documented the injured worker complained of low and mid back pain. The documents submitted failed to indicate the injured worker's outcome measurements while taking Trazodone. Furthermore, the documents submitted failed to indicate the outcome measurements of physical therapy, home exercise regimen, and pain medication management. In addition, the request

lacked frequency, dosage and duration. As such, the request for Trazodone HCL is not medically necessary.

Lunesta #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: Treatment Index, 11th edition, (web), 2013, Pain and Insomnia treatment.

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) & Insomnia.

Decision rationale: The request for Lunesta is not medically necessary. The Official Disability Guidelines (ODG) states that Lunesta is a prescription short-acting non-benzodiazepine 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. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. The documentation that was submitted for review lacked evidence on the duration the injured worker has been on Ambien. In addition, the request did not include the frequency, dosage and duration for the medication for the injured worker. The guidelines do not recommend Ambien for long-term use. Therefore, the continued use of Lunesta is not supported. As such the request is not medically necessary.

Norco #160 refill:1: 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 Opioids, criteria for use Page(s): 78.

Decision rationale: The requested is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) Schedule (MTUS) guidelines state that criteria for use for ongoing- management of opioids include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. There was lack of evidence of opioid medication management and average pain, intensity of pain, or longevity of pain relief. There was no outcome measurements indicated for the injured worker such as physical therapy or home exercise regimen for the injured worker. There was lack of documentation of long-term functional improvement for the injured worker. In addition, the request does not include the frequency, dosage or duration of medication. Given the above, the request for Norco # 160 refill 1 is not medically necessary.