MAXIMUS Federal Services

Case Number:	CM14-0012421		
Date Assigned:	02/21/2014	Date of Injury:	07/26/2006
Decision Date:	08/18/2014	UR Denial Date:	01/16/2014
Priority:	Standard	Application Received:	01/30/2014

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 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 is a 59-year-old female with a 7/26/06 date of injury. On 1/2/14 there was note of neck pain that radiates bilaterally in the upper extremities, as well as left shoulder pain. Pain levels with medication is 5/10 and without 8/10. Clinically, the patient has tenderness in the cervical spine with limited range of motion. There was tenderness at both rotator cuffs. Current medications include Ambien, Lidoderm, Tizanadine, and Tylenol #3.6/20/13 progress note described 8/10 pain levels with medications and 10/10 without medications. Treatment to date has included PT, cervical ESI, suprascapular nerve block, activity modification, and medication. 6/20/13 progress note described 8/10 pain levels with medications and 10/10 without medications. Treatment to date has included PT, cervical ESI, suprascapular nerve block, activity modification, and medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF CELEXA 20MG EVERY DAY, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SSRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS) Page(s): 107.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13 - 14. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter: antidepressants for chronic pain.

Decision rationale: Medical necessity for the requested SSRI obtained an adverse determination due to lack of an up-to-date psychiatric evaluation for a diagnosis of depression. MTUS guidelines do not recommend SSRIs for chronic pain without a secondary diagnosis of depression. The psychiatric diagnosis being treated with Celexa was not discussed in the reviewed medical records. 1/20/14 Diagnosis did not include a psychiatric diagnosis, noting cervical radiculopathy; bilateral CTS; and bilateral shoulder pain. Without discussion of efficacy of this mediation, as well as mood disorder, the request is not established and is therefore not medically necessary.

PRESCRIPTION OF TYLENOL NO. 3, TWICE A DAY, #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS (CODEINE) Page(s): 92.

MAXIMUS guideline: Decision based on the MTUS Chronic Pain Medical Treatment Guidelines, Acetaminophen (APAP), pages 11-12, 16-17.

Decision rationale: The request for Tylenol No 3 obtained an adverse determination due to lack of pain and functional improvement. However, the most recent 1/2/14 Progress note described pain relief with medication; with 5/10 pain levels with medication, and 8/10 without. CA MTUS states that Acetaminophen is indicated for treatment of chronic pain & acute exacerbations of chronic pain and ODG recommends Tylenol with codeine as an option for mild to moderate pain. A CURES report was documented as well as VAS score improvement. The request is medically necessary.

PRESCRIPTION OF AMBIEN 5MG, TAKE 1 BY MOUTH EVERY DAY, #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain Chapter, Zolpidem (Ambien).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on the Non-MTUS, Official Disability Guidelines (ODG) (Pain Chapter) Ambien, and Non-MTUS: FDA, Ambien, and Non-MTUS (http://www.drugs.com/pro/ambien.html).

Decision rationale: Medical necessity for the requested Ambien is not established. ODG and the FDA state that Ambien is approved for the short-term (usually two to six weeks) treatment of insomnia. Additionally, pain specialists rarely, if ever, recommend Ambien for long-term use. With a 2006 date of injury, the duration of use has exceeded guideline recommendations. In addition, the provided progress notes do not further discuss sleep difficulties or education regarding sleep hygiene. The request is not medically necessary.

PRESCRIPTION OF TIZANIDINE HCL 2MG, TAKE 1 BY MOUTH EVERY 8 HOURS, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASMODICS Page(s): 66.

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

Decision rationale: Medical necessity for the requested muscle relaxant is not established. CA MTUS Chronic Pain Medical Treatment Guidelines recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP, however, in most LBP cases; they show no benefit beyond NSAIDs in pain and overall improvement. The patient has a 2006 date of injury, and guidelines do not support chronic pain management with the use of muscle relaxants. There is no documentation of an acute exacerbation. The request is not substantiated and is therefore not medically necessary.