MAXIMUS Federal Services

Case Number:	CM14-0017850		
Date Assigned:	04/16/2014	Date of Injury:	11/30/2002
Decision Date:	07/23/2014	UR Denial Date:	01/28/2014
Priority:	Standard	Application Received:	02/12/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Texas. 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 34-year-old female who reported an injury on 11/30/2002. The mechanism of injury was not provided for review. Current diagnoses included status post right knee surgery, herniated discs of the lumbar spine, atypical seizures, dental caries, emotional and mental instability and lumbosacral chronic pain. The injured worker developed chronic pain that was managed with multiple medications, to include omeprazole 20 mg, nortriptyline 25 mg, Lyrica 100 mg, Celebrex 200 mg, methadone 5 mg, Ambien 10 mg, oxcarbazaepine tablets 150 mg and sumitriptan 50 mg. The injured worker was monitored for aberrant behavior with urine drug screens. The injured worker was evaluated on 12/10/2013. The injured worker complained of bilateral knee pain rated at a 9/10 and low back pain rated at a 9/10 Physical findings included limited lumbar range of motion secondary to pain with decreased sensation in the L5 dermatomal distribution and a positive left-sided straight leg raise test. The injured worker's treatment plan included the continuation of medications and a referral for a psychiatric evaluation. The injured worker was evaluated on 01/07/2014. Samples of Dexilant and a new prescription of Ambien 10 mg were provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORTRIPTYLINE HCL 25MG, #90 WITH 3 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13-16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications For Chronic Pain And Anti-Depressant Page(s): 60, 16.

Decision rationale: The requested nortriptyline hydrochloride 25 mg #90 with 3 refills is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends antidepressants as a first-line medication in the management of chronic pain. The clinical documentation submitted for review supports that the injured worker has been taking this medication since at least 07/2013. The California Medical Treatment Utilization Schedule recommends that ongoing use of medications in the management of chronic pain be supported by documentation of functional benefit and a quantitative assessment of pain relief. The clinical documentation submitted for review indicated that the injured worker had 9/10 pain. However, there was no documentation of how medications affect those pain levels. Additionally, the clinical documentation fails to provide any evidence that the injured worker has any functional benefit related to the medication usage. In addition, the request for three refills does not allow timely re-evaluation to assess the efficacy and need for ongoing treatment. The request as it is submitted does not specifically identify a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested nortriptyline hydrochloride 25 mg #90 with 3 refills is not medically necessary or appropriate.

LYRICA 100MG, #180 WITH 3 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs (Aeds) Outcome Page(s): 17.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications For Chronic Pain And Anti-Epilyptics Page(s): 60, 16.

Decision rationale: The requested Lyrica 100 mg #180 with 3 refills is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does support the use of anticonvulsants as a first-line medication in the management of chronic pain. The clinical documentation indicates that the injured worker has been taking this medication since at least 07/2013. The California Medical Treatment Utilization Schedule also states that any medication that is used in the management of chronic pain must be supported by significant functional benefit and a quantitative assessment of pain relief. The clinical documentation does indicate that the injured worker has 9/10 pain. However, there was no documentation of how this pain level is affected by medication usage. Additionally, the clinical documentation failed to provide any evidence of functional benefit related to the medication usage. In addition, the request is for three refills. This does not allow a timely reassessment to assess for efficacy and the appropriateness of ongoing treatment. In addition, the request does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Lyrica 100 mg #180 with 3 refills is not medically necessary or appropriate.

DEXILANT 60MG, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Nsaids, Gi Symptoms And Cardiovascular Risk, Chronic Pain Medical Treatment Guidelines Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Initiating Therapy Page(s): 77.

Decision rationale: The requested Dexilant 60 mg #30 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends prophylactic treatment for constipation with injured workers who are on chronic opioid therapy. The clinical documentation does indicate that the injured worker is taking opioids and has been since at least 07/2013. However, there was no documentation of side effects, to include constipation that would support the need for this medication. Additionally, the request as it was submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Dexilant 60 mg #30 is not medically necessary or appropriate.

AQUATIC THERAPY 2 TIMES A WEEK FOR 6 WEEKS FOR THE LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22.

Decision rationale: The requested aquatic therapy 2 times a week for 6 weeks for the lumbar spine is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends aquatic therapy for injured workers who require a nonweightbearing environment while participating in active physical therapy. The clinical documentation does not provide any justification for a nonweightbearing environment for the injured worker. Additionally, there was no documentation that the injured worker cannot participate in a land-based therapy program. As such, the requested aquatic therapy 2 times a week for 6 weeks for the lumbar spine is not medically necessary or appropriate.

DEXILANT SAMPLES GIVEN IN THE OFFICE, UNSPECIFIED QUANTITY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Nsaids, Gi Symptoms And Cardiovascular Risk, Chronic Pain Medical Treatment Guidelines Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Initiating Therapy Page(s): 77.

Decision rationale: The requested Dexilant 60 mg #30 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends prophylactic

treatment for constipation with injured workers who are on chronic opioid therapy. The clinical documentation does indicate that the injured worker is taking opioids and has been since at least 07/2013. However, there was no documentation of side effects, to include constipation that would support the need for this medication. Additionally, the request as it was submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Dexilant 60 mg #30 is not medically necessary or appropriate.

AMBIEN 10MG, #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 (Odg) Treatment Index, 11th Edition (Web), 2013, Pain Chapter, Zolpidem (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 Chapter, Insomnia Treatments.

Decision rationale: The requested Ambien 10 mg #30 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this medication. The Official Disability Guidelines support the short-term use of pharmacological interventions such as Ambien for injured workers who have insomnia related to chronic pain. The clinical documentation does not provide an adequate assessment of the injured worker's sleep hygiene to support the need for pharmacological intervention. There was no documentation that the injured worker has failed to respond to nonpharmacological measures and now requires medications. The request as it was submitted failed to identify a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Ambien 10 mg #30 is not medically necessary or appropriate.