

Case Number:	CM14-0177659		
Date Assigned:	10/31/2014	Date of Injury:	08/20/2012
Decision Date:	12/08/2014	UR Denial Date:	09/25/2014
Priority:	Standard	Application Received:	10/27/2014

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 Anesthesia, has a subspecialty in Acupuncture and 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:

64 year old female injured worker with date of injury 8/20/12 with related neck, back, shoulders, arms, hands, fingers, legs, feet, and toe pain. Per progress report dated 9/11/14, the injured worker reported that her pain increased with activity. She used a walker because it was difficult to walk on her own. She experienced frequent numbness in her left hand and fingers, as well as cramps in her left lower extremity. She complained of sleep disruption. Physical exam findings were not documented. Treatment to date had included physical therapy, chiropractic manipulation, acupuncture, and medication management. The date of UR decision was 9/25/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fioricet #60 with 1 refill: 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 Barbiturate-containing analgesic agents Page(s): 23.

Decision rationale: Per MTUS CPMTG with regard to barbiturate-containing analgesic agents: "Not recommended for chronic pain. The potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the

barbiturate constituents. There is a risk of medication overuse as well as rebound headache." As the request is not recommended by the MTUS, the request is not medically necessary.

Norco 5/325 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78, 91.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines page 78 regarding on-going management of opioids "Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: Pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. These domains have been summarized as the '4 s' (Analgesia, activities of daily living, adverse side effects, and any aberrant drug-taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs." Review of the available medical records reveals neither documentation to support the medical necessity of Norco nor any documentation addressing the '4 A's' domains, which is a recommended practice for the on-going management of opioids. Specifically, the notes do not appropriately review and document pain relief, functional status improvement, appropriate medication use, or side effects. The MTUS considers this list of criteria for initiation and continuation of opioids in the context of efficacy required to substantiate medical necessity, and they do not appear to have been addressed by the treating physician in the documentation available for review. Furthermore, efforts to rule out aberrant behavior (e.g. CURES report, UDS, opiate agreement) are necessary to assure safe usage and establish medical necessity. There is no documentation comprehensively addressing this concern in the records available for my review. As MTUS recommends discontinuing opioids if there is no overall improvement in function, medical necessity cannot be affirmed.

Trazodone 50 mg #60 with 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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), Insomnia Treatment

Decision rationale: With regard to insomnia treatment, the ODG guidelines state "Sedating antidepressants (e.g., amitriptyline, trazodone, mirtazapine) have also been used to treat insomnia; however, there is less evidence to support their use for insomnia (Buscemi, 2007) (Morin, 2007), but they may be an option in patients with coexisting depression. (Morin, 2007) Trazodone is one of the most commonly prescribed agents for insomnia. Side effects of this drug include nausea, dry mouth, constipation, drowsiness, and headache. Improvements in sleep onset

may be offset by negative next-day effects such as ease of awakening. Tolerance may develop and rebound insomnia has been found after discontinuation." The documentation submitted for review do not provide information regarding sleep onset, sleep maintenance, sleep quality or next day functioning to support the medical necessity of a sleep aid. Per review of systems on progress report dated 9/11/14, depression was noted; however, there is insufficient information to establish a diagnosis of insomnia. The request is not medically necessary.

Xanax 0.5 mg #60 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines page 24 regarding benzodiazepines, "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. The documentation submitted for review indicates that the injured worker was prescribed Xanax 6/2014. As it is not recommended for long-term use, the request is not medically necessary.