

Case Number:	CM14-0020905		
Date Assigned:	04/30/2014	Date of Injury:	03/07/1997
Decision Date:	07/25/2014	UR Denial Date:	02/11/2014
Priority:	Standard	Application Received:	02/19/2014

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 41 year old male who reported an injury on 03/07/1997 secondary to objects falling on him. The clinical note dated 02/27/2014 reported the injured worker complained of back and leg pain rated at a 3-4/10. He reportedly stated he had insomnia, getting eight hours of interrupted sleep and he is independent with self-care and an exercise program. He reportedly stated he takes Abilify every other day and Pristiq every day. The injured worker also stated he was taking Suboxone which it helped him a lot, and he was taking Flexeril at night which also helped him. The injured worker's medication regimen also reportedly included Senna, Docusate Sodium and Gabapentin for pain. Upon physical examination the injured worker was reported to have good range of motion to his neck and pain upon lumbar range of motion but is functional. His strength was 5/5 throughout his upper and lower extremities. His musculoskeletal system was positive for back pain, stiffness and leg pain. The impressions reportedly included lumbar spondylosis with no neuro deficit, hip bursitis, depression, anxiety, hip pain, opioid dependence, lumbago, and insomnia. The physician treated the injured worker with medication refills and reportedly recommended continued core strengthening and aerobic exercises. The injured worker had an L5 compression fracture that required surgery once in 1997 and again in 2012. The injured worker has participated in a Functional Restoration Program. The request for authorization for Pristiq and Fortesta was submitted on 02/04/2014. The request for authorization for Suboxone, Dexilant and Flexeril was not submitted. A clear rationale was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRISTIQ 50MG #0 WITH 3 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants For Treatment of Major Depressive Disorder Page(s): 13-15.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants For Chronic Pain Page(s): 13-15.

Decision rationale: The injured worker has a history of chronic low back pain, depression and anxiety. Pristiq is an antidepressant FDA-approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. The information, provided for review, states the injured worker has depression and has been taking this medication since at least 06/2013. However, the quantity requested has not been provided. Therefore, the request for Pristiq 50mg is not medically necessary.

FORTESTA PUMP 2% GEL #60GM WITH 3 REFILLS: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Testosterone Replacement For Hypogonadism, Related to Opioids Page(s): 110.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Testosterone Replacement For Hypogonadism, Related to Opioids Page(s): 110.

Decision rationale: The injured worker has a history of opioid dependence which can decrease testosterone levels and cause hypogonadism. The California MTUS Guidelines recommend testosterone replacement therapy for hypogonadism in limited circumstances for patients taking high-dose long-term opioids with documented low testosterone levels. The information provided for review states the injured worker has been on long-term opioid therapy which has necessitated testosterone therapy as evidenced by decreased testosterone levels. The injured worker has been on testosterone therapy since approximately 07/2013 with documented testosterone levels remaining in the normal reference range. Therefore, the request for Fortesta Pump 2% Gel #60gm is medically necessary.

SUBOXONE FILM 8/2MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine Page(s): 26.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine Page(s): 26.

Decision rationale: The injured worker has a history of chronic low back pain with opioid dependence. The California MTUS Guidelines recommend Suboxone which contains a combination of buprenorphine and naloxone for treatment of opiate addiction. Suboxone is also recommended as an option for chronic pain, especially after detoxification in patients who have a history of opiate addiction. Based on the clinical information, provided for review, shows the injured worker began taking this medication in 05/2013 and is currently taking it 3 times daily

resulting in no craving for narcotics and no complaints of withdrawal symptoms. However, the provided request does not state the quantity requested. Therefore, the request for Suboxone Film 8/2mg is not medically necessary.

FLEXERIL 10MG WITH 5 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flexeril, Cyclobenzaprine Page(s): 41-42.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

Decision rationale: The injured worker has a history of low back pain. The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. The guidelines also show efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Based on the clinical information submitted for review, the injured worker has been taking this medication since approximately 07/2013 which exceeds the short term recommendation. In addition, there was no quantity given for this medication request. Therefore, the request for Flexeril 10mg is not medically necessary.

DEXILANT 60MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-Steroidal Anti-Inflammatory Drug (NSAIDs), Gastrointestinal (GI) Symptoms & Cardiovascular Risk Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-Steroidal Anti-Inflammatory Drug (NSAIDs), Gastrointestinal (GI) Symptoms & Cardiovascular Risk Page(s): 68.

Decision rationale: The California MTUS Guidelines recommend Dexilant for injured workers at risk of Gastrointestinal (GI) symptoms. The injured worker has a history of stomach upset due to medication regimen and the clinical information, provided for review, stated the injured worker has ongoing constipation and stomach upset. However, there was no quantity given for this medication request. Therefore, the request for Dexilant 60mg is not medically necessary.

SEROQUEL 50MG: 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), Mental Illness and Stress Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness and Stress Chapter, Atypical Antipsychotics.

Decision rationale: The injured worker has a history of depression. The Official Disability Guidelines (ODG) state that there is insufficient evidence to recommend atypical antipsychotics (Seroquel) for conditions covered in the ODG. Adding an atypical antipsychotic to an antidepressant provides limited improvement in depressive symptoms in adults, new research suggests. The clinical information, provided for review, documents the injured worker suffers from depression and has been taking this medication since approximately 09/2013. However, there was no quantity given for this medication request. Therefore, the request for Seroquel 50mg is not medically necessary.