

<b>Case Number:</b>	CM14-0023882		
<b>Date Assigned:</b>	06/11/2014	<b>Date of Injury:</b>	06/20/2003
<b>Decision Date:</b>	07/18/2014	<b>UR Denial Date:</b>	02/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/25/2014

### 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 Occupational Medicine and is licensed to practice in Wisconsin. 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 began part-time employment in a cafe as a part time cook, sandwich maker and cashier in 2000. In 2003 she began to develop symptoms of pain in her hand and wrists and upper shoulders with any type of repetitive arm motions or carrying. She also developed pain in her low back. She has been diagnosed with chronic pain syndrome. She underwent extensive conservative treatment including physical therapy, acupuncture, injections and chiropractic treatment, as well as right carpal tunnel release and removal of a ventral wrist ganglion, all with no benefit. She was eventually referred to multidisciplinary pain management for chronic pain syndrome in October of 2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 FUNCTIONAL RESTORATION PROGRAM: 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 Functional Restoration Program Page(s): 49.

**Decision rationale:** The guidelines state "There appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other

rehabilitation facilities for neck and shoulder pain..." The injured worker has already been subjected to extensive conservative treatments including PT aimed at restoring function, and her clinical history indicates that she is capable of performing all of her ADAs without specific functional limitations, per physical therapy report of 10/4/13. Therefore, the request for 1 functional restoration program is not medically necessary.

**LEXAPRO 10 MG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Antidepressants for chronic pain..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for chronic pain, Specific Antidepressants: Selective serotonin re-uptake inhibitors Page(s): 13-16, 107.

**Decision rationale:** The guidelines indicate more information is needed regarding the role of SSRIs and pain. Tricyclic antidepressants are recommended over SSR for chronic pain unless adverse reactions are a problem, and the records do not clearly document any adverse reactions in the injured workers case. The medical records indicate the presence of depression. First line treatment of depressant illness is the tricyclic anti-depressants. There is no documentation to indicate that these medications were either ineffective, poorly tolerated, or had severe adverse side effects. Therefore, the request for Lexapro 10mg is not medically necessary.

**NORCO 10/325 MG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines : CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OPIOIDS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines , Opioids for chronic pain Page(s): 79-82.

**Decision rationale:** The Guidelines document specific chronic pain general conditions for which opioids may be indicated, including Neuropathic pain, chronic back pain, headaches, osteoarthritis, nociceptive pain, and mechanical and compressive etiologies. In this case, there is no clear pain etiology. If utilized for the injured worker's chronic back pain, the Guidelines note "...limited for short term pain relief, and long term efficacy is unclear." Furthermore, the records indicate the injured worker has been on long term use of Norco since 2009, with recommendation for eventual weaning. However, there is no documentation of any attempts at decreasing the dosage of this medication or weaning efforts. The guidelines indicate problems with opiate dependency, addiction and abuse associated with long term opiate use. Finally, specific criteria to discontinue opioids is noted on page 79, including "...no overall improvement in functioning" despite the use of opiates since 2009. In the injured worker's case there is little documentation to suggest use of opiates has resulted in any long term improvement in functioning, as noted by her treating provider on 8/1/13 that she remained dysfunctional despite higher doses of Norco. Therefore, the request for Norco 10/325mg is not medically necessary.

**LUNESTA: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Pain (Chronic)..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Insomnia treatment Page(s): 11.

**Decision rationale:** The injured worker has been treated for sleep disturbance chronically with no documentation of efficacy or attempts to more precisely determine etiology. Per the Guidelines cited, pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Although Lunesta has been approved for use longer than 35 days, there is no documentation indicating specific efficacy such as improvement in sleep latency, wake after sleep onset, or total sleep. Finally, increased improvement in overall function has not been demonstrated. Therefore, the request for Lunesta is not medically necessary.

**MULTIDISCIPLINARY PAIN MANAGEMENT REFERRAL: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Management Programs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs Page(s): 65.

**Decision rationale:** The injured worker has already been subjected to extensive conservative treatments including PT aimed at restoring function, and her clinical history indicates that she is capable of performing all of her ADAs without specific functional limitations, per physical therapy report of 10/4/13. There is no evidence of the injured workers degree of motivation to improve functionally and return to work. Therefore, the request for multidisciplinary pain management referral is not medically necessary.