

<b>Case Number:</b>	CM14-0028144		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	08/01/2000
<b>Decision Date:</b>	07/16/2014	<b>UR Denial Date:</b>	01/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/05/2014

### 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 Internal Medicine and Emergency Medicine, and is licensed to practice in Florida. 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:

This patient is a 52 year-old with a date of injury of August 1, 2000. A progress report associated with the request for services, dated December 23, 2013, identified subjective complaints of low back pain. Objective findings included tenderness to palpation of the low back and TMJ (temporomandibular joint). Mood was described as anxious with crying. Diagnoses included lumbar disc disease; TMJ pain; and anxiety/depression. Treatment has included oral analgesics. A Utilization Review determination was rendered on January 30, 2014 recommending non-certification of "APAP/codeine 300/60mg #90, 2 refills; sertraline 50mg #60, 2 refills; But/ASA/Caff #90, 2 refills; and lansoprazole DR 30mg #30, 1 refill".

### IMR ISSUES, DECISIONS AND RATIONALES

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

**APAP/CODEINE 300/60MG #90, 2 REFILLS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308, Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

**Decision rationale:** APAP/Codeine is a combination of the opioid codeine and acetaminophen. The California Medical Treatment Utilization Schedule (MTUS) Guidelines related to on-going

treatment of opioids state that there should be documentation and ongoing review of pain relief, functional status, appropriate use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. A recent epidemiologic study found that opioid treatment for chronic non-malignant pain did not seem to fulfill any of the key outcome goals including pain relief, improved quality of life, and/or improved functional capacity (Eriksen 2006). The documentation submitted lacked a number of the elements listed above, including the level of functional improvement afforded by the chronic opioid therapy. The Guidelines also state that with chronic low back pain, opioid therapy "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (greater than sixteen weeks), but also appears limited." Additionally, "There is also no evidence that opioids showed long-term benefit or improvement in function when used as treatment for chronic back pain (Martell - Annals, 2007)." The MTUS Guidelines further state that opioid therapy is not recommended for the low back beyond two weeks. In this case, there is no documentation of the elements of the pain assessment for initial therapy referenced above or the length of intended use. The request for APAP/Codeine 300/60mg, ninety count with two refills, is not medically necessary or appropriate.

**SERTRALINE 50MG #60, 2 REFILLS:** Upheld

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

**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 & Stress, Antidepressants; Antidepressants for Treatment of MDD Other Medical Treatment Guideline or Medical Evidence: UpToDate: Unipolar minor depression in adults: Management and treatment.

**Decision rationale:** Zoloft (sertraline) is an SSRI (selective serotonin reuptake inhibitor) class antidepressant. The California Medical Treatment Utilization Schedule (MTUS) does not address depression. The Official Disability Guidelines (ODG) state that cognitive and behavioral therapy are recommended and are standard treatment for mild presentation of major depressive disorders. They may be used in combination with antidepressant medications or alone. The Guidelines further note that antidepressants are recommended, although generally not as stand-alone treatment. They are recommended for initial treatment of major depressive disorders that are moderate, severe, or psychotic. They state that antidepressants offer significant benefit in the treatment of the severest depressive symptoms, but may have little or no therapeutic benefit over and above placebo in patients with mild to moderate depression. Authoritative sources such as UpToDate state that "treatment of minor depression with antidepressant medication monotherapy is generally not recommended." There appears to be no absolute advantage of the reuptake inhibitors versus tricyclic antidepressants. In this case, the record implies that the patient has minor depression and there is no documentation of major depression. The request for Sertraline 50mg, sixty count with two refills, is not medically necessary or appropriate.

**BUT/ASA/CAFF #90, 2 REFILLS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-Containing Analgesic Agents Page(s): 23.

**Decision rationale:** The Medical Treatment Utilization Schedule (MTUS) states that barbiturate-containing analgesics (BCAs) are not recommended for chronic pain. There is no evidence that the barbiturate constituents of BCAs enhance their analgesic efficacy. Also, there is a high potential for drug dependence with these agents. The request for But/ASA/Caff, ninety count with two refills, is not medically necessary or appropriate.

**LANSOPRAZOLE DR 30MG #30, 1 REFILL:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Proton Pump Inhibitors.

**Decision rationale:** Prevacid (lansoprazole) is a proton pump inhibitor (PPI) antacid. The Medical Treatment Utilization Schedule (MTUS) does not address their use related to medication gastrointestinal side-effects other than with NSAIDs (non-steroidal anti-inflammatory drugs). The Official Disability Guidelines (ODG) notes that PPIs are recommended for patients at risk for gastrointestinal events. It also notes that a trial of omeprazole or lansoprazole is recommended before non-generic Nexium (esomeprazole). The record does not indicate that the patient has gastrointestinal side-effects from medications or other gastrointestinal symptoms. The request for Lansoprazole DR 30 mg, thirty count with one refill, is not medically necessary or appropriate.