

Case Number:	CM14-0060924		
Date Assigned:	07/09/2014	Date of Injury:	01/24/2005
Decision Date:	09/05/2014	UR Denial Date:	04/11/2014
Priority:	Standard	Application Received:	05/01/2014

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 Montana. 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 female management services technician with a cumulative trauma condition related to a date of injury of 1/24/05. The carrier has approved claims for both upper extremities, and right elbow. She is currently retired and has not worked since 2007. Bilateral electro diagnostic tests were normal. An MRI of the right shoulder showed degenerative changes with probable impingement and tendinopathy. She did have an acromioplasty with distal clavicle resection. Current diagnoses include cervical discogenic pain status post radiofrequency ablation, neuropathic pain, right shoulder impingement status post decompression and distal clavicle resection, overuse left shoulder and upper extremity, sleep disorder, gastroesophageal reflux disease, headaches, and TMJ syndrome. Medications include Trazodone, Flexeril, gabapentin, Norco, Motrin and Zantac. The primary treating physician notes that medications are required to remain functional.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 mg, QTY: 90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 75, 78, 79 and 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 78-79.

Decision rationale: Norco is an opioid medication containing Hydrocodone. The MTUS notes that ongoing management of pain with opioid medication should be provided by a single provider with the lowest possible dose prescribed to improve pain and functioning. Her current dose does appear to decrease pain level significantly and improve function as noted in the medical records. There is no evidence for misuse, escalation, or diversion. Her dose does appear to be stable over time. This injured worker, who has been on Norco for years with functional improvement noted, does not meet the MTUS guidelines for immediate discontinuation. At this time, with multiple approvals of Norco over a long-term basis, the request is medically necessary.

Trazodone 50 mg, QTY: 60: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (updated 3/27/14) Sedating Antidepressants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIDEPRESSANTS FOR CHRONIC PAIN Page(s): 13-14. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Formulary, Trazodone.

Decision rationale: The MTUS recommends antidepressants, such as Trazodone, as a first-line option for neuropathic pain, and as a possibility for non-neuropathic pain. The Official Disability Guidelines recommend Trazodone as an option for insomnia for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. There is limited evidence to support its use for insomnia, but it may be an option in patients with coexisting depression. Trazodone was used successfully for fibromyalgia. Trazodone was approved in 1982 for the treatment of depression. It is unrelated to tricyclic or tetracyclic antidepressants and has some action as an anxiolytic. Off-label uses include alcoholism, anxiety, insomnia, and panic disorder. Although approved to treat depression, the American Psychiatric Association notes that it is not typically used for major depressive disorder. Between 1987 and 1996, prescribing Trazodone for depression decreased, while off-label use of the drug for insomnia increased steadily until it was the most frequently prescribed insomnia agent. To date, there has been only one randomized, double blind, placebo-controlled trial studying trazodone in primary insomnia. It was observed that relative to placebo, patients reported significant improvement in subjective sleep latency, sleep duration, wake time after sleep onset, and sleep quality with trazodone and zolpidem during week one, but during week two the trazodone group did not differ significantly from the placebo group whereas the zolpidem group demonstrated significant improvement compared to placebo for sleep latency and sleep duration. The AHRQ Comparative Effectiveness Research on insomnia concludes that trazodone is equal to zolpidem. Evidence for the off-label use of trazodone for treatment of insomnia is weak. The current recommendation is to utilize a combined pharmacologic and psychological and behavior treatment when primary insomnia is diagnosed. It is also worth noting that there has been no dose-finding study performed to assess the dose of trazodone for insomnia in non-depressed patients. Other pharmacologic therapies should be recommended for primary insomnia before considering trazodone, especially if the insomnia is not accompanied by comorbid depression or recurrent treatment failure. There is no

clear-cut evidence to recommend trazodone first line to treat primary insomnia. In this case the injured worker does have sleep disturbances, but the trazodone is used primarily as treatment for neuropathic pain. Medical records do document functional improvement related to his treatment regimen. The utilization review (UR) stated that continued certification was dependent on ongoing documentation of functional improvement. Having been previously approved with some efficacy documented, the request is medically necessary.

Gabapentin 600 mg, QTY: 90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 49.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTI-EPILEPSY DRUGS Page(s): 16-17.

Decision rationale: Gabapentin is an anti-epilepsy drug. The MTUS recommends the use of gabapentin for neuropathic pain. A good response to the use of antiepileptic drugs defined as a 50% reduction in pain. In this case the medical records reviewed document greater than 50% reduction in pain with her current treatment regimen. Gabapentin had previously been approved through the utilization review process. The medical records have adequately documented functional improvement and that her current medication regimen is required to maintain that improvement. The request is medically necessary.

Motrin 800 mg, QTY: 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22 and 72.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Nonsteroidal Anti-Inflammatory Drugs Page(s): 67-68.

Decision rationale: Motrin (Ibuprofen) is a nonsteroidal anti-inflammatory drug (NSAID). The MTUS states that nonsteroidal anti-inflammatory medications are recommended at the lowest dose for the shortest period possible in patients with moderate to severe pain. Although NSAIDs are effective, they can cause gastrointestinal irritation or ulceration. Studies also show that NSAID use for more than a few weeks can retard or impair bone, muscle, and connective tissue healing and may cause hypertension. Regarding neuropathic pain, the guidelines note inconsistent evidence for the use of these medications to treat long-term neuropathic pain but they may be useful to treat breakthrough pain. The primary care provider should weigh the indications for nonsteroidal anti-inflammatory drugs against both gastrointestinal and cardiovascular risk factors. In this case the medical records do document a history of gastritis and gastrointestinal problems associated with her current treatment regimen. Given her long-term use and risk factors for gastrointestinal side effects, the request is not medically necessary.

Zantac 150 mg, QTY: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (Non-Steroidal Anti-Inflammatory Drugs) GI Symptoms & Cardiovascular Risk Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS & CARDIOVASCULAR RISK Page(s): 69.

Decision rationale: Zantac is an H2 receptor antagonists used for treatment of dyspepsia. The MTUS notes that H2 receptor antagonists, such as Zantac, may be used in treatment of dyspepsia secondary to NSAID therapy. The use of ibuprofen has been determined to be not medically necessary. As such the request is not medically necessary.