

Case Number:	CM14-0200464		
Date Assigned:	12/10/2014	Date of Injury:	04/23/2004
Decision Date:	01/28/2015	UR Denial Date:	11/20/2014
Priority:	Standard	Application Received:	12/01/2014

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 Physical Medicine Rehab, has a subspecialty in Interventional Spine 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:

The patient is a 51 year old female with an injury date of 04/23/04. Based on the 02/25/14 progress report, the patient complains of right wrist pain which is exacerbated with any gripping/grasping. She wears a volar wrist splint on her right wrist. She has tenderness along the dorsum of the wrist and pain with flexion/extension of wrist. The 05/20/14 report indicates that the patient continues to have right wrist pain and weakness. No additional positive exam findings were provided on this report. The 08/14/14 report states that the patient still has right wrist pain which is exacerbated with any use of the hand and wrist. No further positive exam findings were provided. The patient's diagnoses include the following: Chronic right wrist pain Psychological diagnosis Chronic pain syndrome Internal medicine diagnosis The utilization review determination being challenged is dated 11/20/14. There were three treatment reports provided from 02/25/14, 05/20/14, and 08/14/14 which were all brief.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lexapro 10 mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.lexapro.com/prescribing-information-pi.aspx>

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants. Page(s): 13-15. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress Chapter and Escitalopram

Decision rationale: The patient presents with right wrist pain/weakness with tenderness along the dorsum of the wrist and pain with flexion/extension. The request is for Lexapro 10 mg. The report with the request was not provided. Lexapro (Escitalopram) is an antidepressant belonging to a group of drugs called selective serotonin re-uptake inhibitors (SSRIs). MTUS guidelines for SSRIs state, "It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain." ODG Guidelines, under Mental Illness and Stress Chapter and Escitalopram section state that Lexapro is "Recommended as a first-line treatment option for MDD and PTSD." In this case, the treating physician only discusses the patient's right wrist pain. There is no discussion provided regarding Lexapro nor is there any indication that the patient is suffering from major depression or from post-traumatic stress disorder. There is no discussion regarding psychological symptoms or sequelae from chronic pain for which this medication may be indicated. Therefore, the requested Lexapro is not medically necessary.

Buspar 10 mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/pro/buspar.html>

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), Chapter, Anxiety medications in chronic pain

Decision rationale: The patient presents with right wrist pain/weakness with tenderness along the dorsum of the wrist and pain with flexion/extension. The request is for Buspar 10 mg. The report with the request was not provided. Regarding Buspar, MTUS guidelines are silent. MTUS guidelines do not discuss anti-anxiety medications. Regarding anti-anxiety medications, ODG guidelines state "Recommend diagnosing and controlling anxiety as an important part of chronic pain treatment, including treatment with anxiety medications based on specific DSM-IV diagnosis as described below." ODG guidelines state that Buspar is "also approved for short-term relief of anxiety symptoms." In this case, there is no discussion provided regarding Buspar. Review of the available reports does not indicate that the patient has anxiety, as required by ODG guidelines. Therefore, the requested Buspar is not medically necessary.

Seroquel 30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH001030/>

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 chapter, Atypical antipsychotics

Decision rationale: The patient presents with right wrist pain/weakness with tenderness along the dorsum of the wrist and pain with flexion/extension. The request is for Seroquel 30. The report with the request was not provided. ODG guidelines, under the Mental Illness and Stress chapter and Atypical Antipsychotics section indicate the following: "Not recommended as a first-line treatment. There is insufficient evidence to recommend atypical antipsychotics (eg, quetiapine, risperidone) for conditions covered in ODG." The guidelines go on and state "off-label use of these drugs in people over 40 should be short-term, and undertaken with caution. (Jin, 2013)." Review of the reports does not provide any discussion regarding Seroquel. It is unknown when the patient began taking this medication and if she is taking it on a short-term basis, as required by ODG guidelines. In addition, there is no documentation of what other first-line treatments the patient has had prior to Seroquel. The requested Seroquel is not medically necessary.

Temazepam 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) chapter, Insomnia treatment.

Decision rationale: The patient presents with right wrist pain/weakness with tenderness along the dorsum of the wrist and pain with flexion/extension. The request is for Temazepam 30. The report with the request was not provided. The MTUS Guidelines page 24 states, "benzodiazepines are not recommended for long-term use because long-term efficacies are unproven and there is a risk of dependence." ODG guidelines have the following regarding insomnia treatments: "Benzodiazepines: Temazepam (Restoril) is FDA-approved for sleep-onset insomnia. These medications are only recommended for short-term use due to risk of tolerance, dependence, and adverse events. Particular concern is noted for patients at risk for abuse or addiction. Benzodiazepines are similar in efficacy to benzodiazepine-receptor agonists; however, the less desirable side-effect profile limits their use as a first-line agent, particularly for long-term use." The medical record provided does not indicate when the patient began taking Temazepam, nor is there any discussion provided regarding if it is intended for short-term use. In addition, there is no documentation that this patient suffers from insomnia. This requested Temazepam is not medically necessary.

Prevacid 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk. Page(s): 68-69.

Decision rationale: The patient presents with right wrist pain/weakness with tenderness along the dorsum of the wrist and pain with flexion/extension. The request is for Prevacid 30. The report with the request was not provided. MTUS Guidelines page 68 and 69 state that omeprazole is recommended with precaution for patients at risk for gastrointestinal events: 1.) Ages greater than 65. 2.) History of peptic ulcer disease and GI bleeding or perforation. 3.) Concurrent use of ASA or corticosteroid and/or anticoagulant. 4.) High-dose/multiple NSAID. MTUS page 69 states "NSAIDs, GI symptoms and cardiovascular risk: Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." The 08/14/14 report states that the patient is currently taking Tylenol #3 and Flector Patches. In this case, the treater does not document dyspepsia or GI issues in any of the three reports provided. Routine prophylactic use of PPI without documentation of gastric issues is not supported by the guidelines without GI-risk assessment. The patient is not even on any oral NSAIDs to be concerned about GI prophylactic use. The requested Prevacid is not medically necessary.

Bupropion: 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)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Regarding antidepressants. Page(s): 13 to 15.

Decision rationale: The patient presents with right wrist pain/weakness with tenderness along the dorsum of the wrist and pain with flexion/extension. The request is for Bupropion. The report with the request was not provided. MTUS Guidelines regarding antidepressants page 13 to 15 states, "While bupropion has shown some efficacy in neuropathic pain, there is no evidence of efficacy on patient with non-neuropathic chronic low back pain." There is no discussion provided regarding Bupropion. The treater documents right wrist pain/weakness and there is no indication that the patient has any neuropathic pain. The requested Bupropion is not medically necessary.