MAXIMUS Federal Services

Case Number:	CM14-0202396		
Date Assigned:	12/15/2014	Date of Injury:	03/26/2009
Decision Date:	02/03/2015	UR Denial Date:	11/19/2014
Priority:	Standard	Application Received:	12/03/2014

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 Psychiatrist (MD), has a subspecialty in Neurology, Addiction Medicine, Geriatric Psychiatry 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:

Records reviewed include 961 pages of medical and administrative records. The injured worker is a 55 year old male whose date of injury is 03/26/2009, during the course of his employment as a housekeeping aide. Diagnoses include lumbar disc disorder, lumbar facet syndrome, cervical disc degeneration, brachial neuritis or radiculitis NOS, depression NOS, lumbago, and thoracic or lumbosacral neuritis or radiculitis NOS. He also has hypertension. He was treated with lumbar epidural injections and pain medications. A psychiatric AME was performed on 02/15/12, along with a failed attempt at psychological testing (the patient vomited). He was on tizanidine, atenolol, bupropion, fentanyl, and Norco. He was diagnosed with anxiety disorder NOS. Suggestions were continuation of bupropion and start Remeron 15mg. Fentanyl was discontinued at some point between 10/01/14 and 11/18/14. A pain management visit of 11/18/14 indicated that he continued to experience lower back pain with radiation into both legs, muscle spasms, tingling, and weakness. Morphine had been tapered to 120 meq. He was able to work full time with pain control medications. He is able to do more household ADL's. Emotionally he is more stable and less irritable/emotionally labile than without meds. He was on Wellbutrin XL, Colace, Percocet, and Morphine sulfate. Pain was rated as 2/10 without medications, 9/10 without. He had tenderness and spasms bilaterally at paravertebral muscles. There is an appeal for denial dated 01/22/15 from [redacted]. She notes that the patient has never been prescribed these medications by her office, these medications have never been requested, and CURES report reflects that the patient has never been dispensed these medications from a California pharmacy. [redacted] submitted that this appears to be a clerical error on the part of the claim adjustor, and an RFA for these medications was never submitted for review by her office.

IMR ISSUES, DECISIONS AND RATIONALES

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

Amobarbital: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs) Page(s): 23.

Decision rationale: The patient had not been prescribed amobarbital anywhere in records reviewed. Per [redacted], her office had not requested this medication and had not prescribed it for the patient. She noted that it appeared to be a clerical error. This request is therefore not medically necessary.CA-MTUS 2009 Chronic Pain Medical Treatment GuidelinesBarbiturate-containing analgesic agents (BCAs)Not recommended for chronic pain. The potential for drug dependence is high and no evidenceexists to show a clinically important enhancement of analgesic efficacy of BCAs due to thebarbiturate constituents. (McLean, 2000) There is a risk of medication overuse as well asrebound headache. (Friedman, 1987). See also Opioids.

Alprazolam: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The patient had not been prescribed alprazolam recently in records reviewed. Per [redacted], her office had not requested this medication and had not prescribed it for the patient. She noted that it appeared to be a clerical error. This request is therefore not medically necessary.CA-MTUS 2009 Chronic Pain Medical Treatment GuidelinesBenzodiazepinesNot recommended for long-term use because long-term efficacy is unproven and there is a riskof dependence. Most guidelines limit use to 4 weeks. Their range of action includessedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines arethe treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly.Tolerance to anxiolytic effects occurs within months and long-term use may actually increaseanxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance toanticonvulsant and muscle relaxant effects occurs within weeks. (Baillargeon, 2003) (Ashton,2005).

Clonazepam: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The patient had not been prescribed clonazepam in records reviewed. Per [redacted], her office had not requested this medication and had not prescribed it for the patient. She noted that it appeared to be a clerical error. This request is therefore not medically necessary.BenzodiazepinesNot recommended for long-term use because long-term efficacy is unproven and there is a riskof dependence. Most guidelines limit use to 4 weeks. Their range of action includessedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines arethe treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly.Tolerance to anxiolytic effects occurs within months and long-term use may actually increaseanxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance toanticonvulsant and muscle relaxant effects occurs within weeks. (Baillargeon, 2003) (Ashton,(2005).