Case Number:	CM15-0108058		
Date Assigned:	06/12/2015	Date of Injury:	03/21/1991
Decision Date:	09/24/2015	UR Denial Date:	05/02/2015
Priority:	Standard	Application Received:	06/04/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 57-year-old male, who sustained an industrial injury on 3/21/91. The diagnoses have included other symptoms referable to back, thoracic or lumbosacral neuritis or radiculitis, lumbosacral spondylosis without myelopathy, displacement of lumbar intervertebral disc without myelopathy, intervertebral lumbar disc disorder with myelopathy, headache, sleep disturbance, post- traumatic stress disorder, degeneration of thoracic disc and anxiety/ depression. He has a history of hypertension. Treatment to date has included medications, activity modifications, off work, diagnostics, surgery, physical therapy, psychiatric, other modalities and home exercise program (HEP). Currently, as per the physician progress note dated 4/20/15, the injured worker is in for medication pre-fills and states that the pharmacy has not re-filled medications because it is too early and he states that he is having withdrawal symptoms. He reports joint and muscle aches, migraines, numbness, weakness, tingling, pins and needles, depression, trouble remembering, anxiety, fear and trouble falling asleep and staying asleep. The physical exam reveals that the injured worker is in moderate pain and guarding in the area of injury. The sitting and standing tolerance is limited. The lumbar spine has 3+ tenderness with myospasm. There is decreased range of motion in the lumbar spine and multiple trigger points are present. The injured worker states that he will be driven to possible suicide if he cannot get analgesic relief and states that he will be bedridden at the very least. The current medications included Cialis, Norco, Soma, Lexapro, Risperdal, Omeprazole, Mirtazapine, Klonopin, Imitrex, Gabapentin, Duragesic patch, Tegaderm pad, Tranzgel, and Viagra. There is no previous urine drug screen report noted in the records. The physician requested treatments included Tegaderm Pad 10 per month, Gabapentin 400mg #90, Mirtazapine Tab 30mg #30, Klonopin 1mg #100, Risperdal 1mg #90, Omeprazole Magnesium 20. 6mg #30, Soma 350mg #90, Lexapro 10mg #60, Viagra 50mg #30, Duragesic Patch 100mcg #15, and Norco 10/325mg #210.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tegaderm Pad 10 per month: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Wound dressings, Low Back - Lumbar & Thoracic (Acute & Chronic).

Decision rationale: The Official Disability Guidelines recommend the following combinations: for chronic wounds, (1) debridement stage, hydrogels; (2) granulation stage, foam and low- adherence dressings; and (3) epithelialization stage, hydrocolloid and low-adherence dressings; and for the epithelialization stage of acute wounds, low-adherence dressings. The patient does not meet any of the above criteria set forth by the ODG in regards to Tegaderm pads. Tegaderm Pad 10 per month are not medically necessary.

Gabapentin 400mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 19.

Decision rationale: The MTUS states that gabapentin is an anti-epilepsy drug which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. An adequate trial period for gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. With each office visit the patient should be asked if there has been a change in the patient's pain symptoms, with the recommended change being at least 30%. There is no documentation of any functional improvement. Gabapentin 400mg #90 is not medically necessary.

Mirtazapine Tab 30mg #30: Upheld

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

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), Antidepressants for chronic pain.

Decision rationale: Mirtazapine is a tetracyclic antidepressant used to treat depression and anxiety disorders. The Official Disability Guidelines recommend numerous antidepressants in a number of classes for treating depression and chronic pain. Mirtazapine is not contained within the current recommendations by the ODG. Mirtazapine Tab 30mg #30 is not medically necessary.

Klonopin 1mg #100: Upheld

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

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

Decision rationale: The MTUS states that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the 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 increase anxiety. Klonopin 1mg #100 is not medically necessary.

Risperdal 1mg #90: Overturned

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) Pain (Chronic), Anxiety medications in chronic pain.

Decision rationale: Risperdal has been prescribed as a sleep aid for this patient. The MTUS is silent, but the Official Disability Guidelines state that atypical antipsychotic such as Risperdal can sometimes be recommended as a second-line agent in the treatment of anxiety disorders which sometimes produce poor sleep. There is documentation that the patient carries a diagnosis of anxiety disorder. I am reversing the previous utilization review decision. Risperdal 1mg #90 is medically necessary.

Omeprazole 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, prior to starting the patient on a proton pump inhibitor, physicians are asked to evaluate the patient and to determine if the patient is at risk for gastrointestinal events. Criteria used are: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID. There is no documentation that the patient has any of the risk factors needed to recommend the proton pump inhibitor omeprazole. Omeprazole 20mg #30 is not medically necessary.

Soma 350mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29.

Decision rationale: The MTUS states that carisoprodol is not recommended and is not indicated for long-term use. Abuse has been noted for sedative and relaxant effects. In regular abusers the main concern is the accumulation of meprobamate. There was a 300% increase in numbers of emergency room episodes related to carisoprodol from 1994 to 2005. There is little research in terms of weaning of high dose carisoprodol and there is no standard treatment regimen for patients with known dependence. Soma 350mg #90 is not medically necessary.

Lexapro 10mg #60: 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) Pain (Chronic), SSRIs (selective serotonin reuptake inhibitors).

Decision rationale: According to the Official Disability Guidelines SSRIs are not recommended as a treatment for chronic pain, but SSRIs may have a role in treating secondary depression. It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain. More information is needed regarding the role of SSRIs and pain. SSRIs have not been shown to be effective for low back pain. Lexapro 10mg #60 is not medically necessary.

Viagra 50mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross Pharmacy Policy Bulletin, Title: Erectile Dysfunction Agents, Policy #: Rx. 01.29, Policy Version Number: 4. 00, P&T Approval Date: July 10, 2014.

Decision rationale: Sildenafil (Viagra) and tadalafil (Cialis) are approved when ALL of the following inclusion criteria are met: 1. Diagnosis of erectile dysfunction. 2. No concurrent use of nitrates. 3. Any one of the following: a. Member is 55 years of age or older. b. Documentation of a concomitant condition (such as diabetes, prostate cancer, pelvic surgery/radiation [e.g., colon cancer], spinal cord injury, neurological disease). c. Documentation of a normal testosterone level. d. Documentation of a low testosterone level and a low or normal prolactin level, with an inadequate response or inability to tolerate a testosterone replacement producte. Documentation of a low testosterone level and a high prolactin level, with evidence of appropriate work up and treatment plan (treatment plan must

be provided with this request). In addition, tadalafil (Cialis) is approved when there is documentation of BOTH of the following inclusion criteria are met: 1. Diagnosis of BPH. 2. Inadequate response or inability to tolerate an alpha blocker. Documentation in the patient's medical record fails to meet the above inclusion criteria. Viagra 50mg #30 is not medically necessary.

Duragesic Patch 100mcg #15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60.

Decision rationale: According to the MTUS in regard to medications for chronic pain, only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. A record of pain and function with the medication should be recorded. According to this citation from the MTUS, medications should not be initiated in a group fashion, and specific benefit with respect to pain and function should be documented for each medication. There is no documentation of the above criteria for either of the narcotics that the patient has been taking.
Duragesic Patch 100mcg #15 is not medically necessary.

Norco 10/325mg #210: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-94.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of Norco, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 6 months. Norco 10/325mg #210 is not medically necessary.