

Case Number:	CM15-0018333		
Date Assigned:	02/06/2015	Date of Injury:	12/15/2011
Decision Date:	04/07/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/30/2015

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: Physical Medicine & Rehabilitation

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 47-year-old female, with a reported date of injury of 12/15/2011. The diagnoses include chronic pain syndrome, right shoulder pain, right rotator cuff syndrome, and improved narcotic dependency. Treatments have included Trazodone, Gralise, Cymbalta, Ambien, Suboxone, and cognitive behavioral therapy. The progress report dated 12/05/2014 indicates that the injured worker complained of right shoulder pain. She rated her pain 6 out of 10. The medications decrease the pain from 7 out of 10 to 5 out of 10, they allow for increase in activity tolerance and home exercise, with no side effects. The objective findings include decreased, guarded, painful range of motion with diffuse tenderness to palpation of the right shoulder. The treating physician requested cognitive behavioral therapy to assist with continued weaning of Suboxone, Ambien, and Gralise. On 12/23/2014, Utilization Review (UR) denied the request for continued Cognitive Behavioral Therapy (CBT), Ambien, and Gralise, noting that there was no evidence to confirm functional improvement related to CBT, no documentation to justify the continued long-term administration of Ambien or to justify the dosage schedule of 10mg, and no evidence of neuropathic pain. The MTUS Guidelines, the non-MTUS Official Disability Guidelines, and the Food and Drug Administration (FDA) were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continued CBT (Cognitive Behavioral Therapy): 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), Cognitive Behavioral Therapy Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cognitive Behavioral Therapy Page(s): 23.

Decision rationale: According to the 12/15/2014 report, this patient presents with 6/10 right shoulder pain that is constant, achy/burning, worse with reaching/twisting. The current request is for Continued Cognitive Behavioral Therapy "to assist with continued weaning of Suboxone." The request for authorization is on 12/19/2014. The patient's disability status is "Permanent and Stationary." For cognitive behavioral therapy, the MTUS Guidelines page 23 recommends an initial trial of 3 to 4 psychotherapy treatments over 2 weeks and additional treatments for a total of 6 to 10 visits with documented functional improvement. In reviewing the provided reports, the Utilization Review denial letter states "The claimant has been afforded an unspecified number of sessions of CBT and there is a request for additional CBT. However, no evidence has been submitted to confirm functional improvement attributable to this program." In this case, the behavioral therapy reports are not provided for review. The treating physician does not provide documentation of functional improvement from prior sessions to consider additional treatment. In addition, it is unclear how many sessions the patient has completed as to date; and the treating physician requested to Continued Cognitive Behavioral Therapy with unknown sessions. This request IS NOT medically necessary.

Ambien: 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), Zolpidem Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Pain Chapter, Insomnia Treatment, Non-Benzodiazepine sedative-hypnotics (Benzodiazepine-receptor agonists).

Decision rationale: According to the 12/15/2014 report, this patient presents with 6/10 right shoulder pain that is constant, achy/burning, worse with reaching/twisting. The current request is for Ambien. The request for authorization is on 12/19/2014; with the request for Ambien 10mg #20. The MTUS and ACOEM Guidelines do not address Ambien; however, ODG Guidelines states that zolpidem (Ambien) is indicated for short-term treatment of insomnia with difficulty of sleep onset 7 to 10 days. A short course of 7 to 10 days may be indicated for insomnia, however, the treating physician is requesting 10mg #20. The treating physician does not mention that this is for a short-term use. ODG Guidelines does not recommend more than 10 day usage of this medication. The request IS NOT medically necessary.

Gralise: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs Section.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs), Gabapentin (Neurontin) Page(s): 18-19, 49.

Decision rationale: According to the 12/15/2014 report, this patient presents with 6/10 right shoulder pain that is constant with numbness. The current request is for Gralise. The request for authorization is on 12/19/2014; with the request for Gralise 600mg #60. Regarding Anti-epileptic (AKA anti-convulsants) drugs for pain, MTUS Guidelines recommend for "treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain." Review of the provided reports indicates that the patient has neuropathic pain. The ODG guidelines support the use of anti-convulsants for neuropathic pain. The treating physician indicates "Meds decrease pain from 7/10 to 5/10, allow for increase in activity tolerance and home exercise, no side effects." In this case, the patient presents with neuropathic pain and the treating physician documented the efficacy of the medication as required by the MTUS guidelines. However, the request does not include the prescription dosing; without knowing the prescription, dosing one cannot make the appropriate recommendation. The request IS NOT medically necessary.