

Case Number:	CM15-0121612		
Date Assigned:	07/08/2015	Date of Injury:	07/27/2011
Decision Date:	11/19/2015	UR Denial Date:	06/15/2015
Priority:	Standard	Application Received:	06/23/2015

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: New York

Certification(s)/Specialty: Pediatrics, Internal 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 29 year old male who sustained an industrial injury on 07-27-2011. Current diagnoses include right elbow sprain, right ulnar neuritis, right carpal tunnel syndrome, double crush syndrome, cervical radiculopathy, and neurovascular thoracic outlet syndrome with double (triple) crush injury. Report dated 06-05-2015 noted that the injured worker presented with complaints that included depression, pain in the upper back neck, and evolving low back pain. Pain level was 3-6 out of 10 on a visual analog scale (VAS). Physical examination was positive for tenderness in the right medial elbow at the cubital tunnel with positive elbow flexion test and discomfort, positive Tinel's at the elbow into the fourth and fifth fingers, decreased right neck range of motion with positive Spurling's, right elbow flexion 130 degrees with increasing elbow pain and fourth and fifth finger pain, tenderness in multiple points of the upper back, and right shoulder raises 90 degrees with increasing pain. Previous treatments included medications, neck decompression, therapy, acupuncture, and epidural injection. The treatment plan included obtaining authorization for medications and treatment plan and maximize non-opiate and non- benzodiazepine interventions such as Lyrica, acupuncture, and physical therapy, and needs a pain management follow up given his ongoing improved upper extremity symptoms he may be a candidate for a repeat epidural. Currently the injured worker is not working. Request for authorization dated 06-05-2015, included requests for Oxycontin, Percocet, clonidine HCL, alprazolam, docusate sodium, trazodone HCL, Pristiq, Lexapro, Lyrica, and Seroquel. The utilization review dated 06-15-2015, modified the request for trazodone HCL, Pristiq, Lexapro, Lyrica, Oxycontin, Percocet, clonidine HCL, and alprazolam.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazodone HCL 50mg #60 x 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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 - trazodone.

Decision rationale: Per ODG guidelines, pharmacological agents for insomnia should only be used after careful evaluation of potential causes of sleep disturbance for the etiology and trazodone is recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. Trazodone is not recommended as a first-line treatment for insomnia in patients generally, or as a first-line treatment for depression or for pain. 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. The documentation states that the IW had tried and failed other treatments for sleep and depression but there are no specific drugs or outcomes noted. There is no discussion of an investigation into the origin of the sleep disturbance and non-pharmacological interventions that may have been utilized or improvement in sleep while utilizing the trazodone. Additionally, the dose requested is not appropriate as the dosage is a range of pills and not a standing dose. This request is not medically necessary and appropriate.

Pristiq 50mg #60 x 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental/Stress - Desvenlafaxine (Pristiq).

Decision rationale: Per ODG guidelines, desvenlafaxine is recommended for depression and as an option in first-line treatment of neuropathic pain, especially if tricyclics are ineffective, poorly tolerated, or contraindicated. Pristiq (desvenlafaxine) is a serotonin and norepinephrine reuptake inhibitor (SNRI). There is no documentation of neuropathic pain in the case file there are positive compression tests noted but no baseline numbness, tingling, muscle weakness or wasting. Additionally, the documentation states that the IW had tried and failed other treatments for depression but there are no specific drugs or outcomes noted. Without this information medical necessity cannot be established. Additionally, there is no notation that the IW was responding to the medication with decreasing symptoms of depression or anxiety. This request is not medically necessary and appropriate.

Lexapro 10mg #30 x 6 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental/Stress - Escitalopram (Lexapro®).

Decision rationale: Per ODG guidelines, Lexapro is recommended as a first-line treatment option for MDD and PTSD or anxiety disorder. The documentation states that the IW is becoming progressively more depressed but there is no notation of MDD, PTSD or an anxiety disorder being treated. Without these diagnoses, medical necessity cannot be established. Additionally, there is no notation that the IW was responding to the medication with decreasing symptoms of depression or anxiety. This request is not medically necessary and appropriate.

Lyrica 150mg #90 x 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Anti-epilepsy drugs (AEDs).

Decision rationale: Per MTUS guidelines, antiepileptic drugs are recommended for neuropathic pain. A good response to the use of AEDs has been defined as a 50% reduction in pain and a moderate response as a 30% reduction. The patient should be asked at each visit as to whether there has been a change in pain or function. It is noted that there is no EMG/NCV in the case file to document neuropathy in the IW and physical examination was inconsistent. There was documentation of objective functional benefit with prior use of this medication but without documentation of neuropathy, the request is not medically necessary and appropriate.

Oxycontin 10mg 12H #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: The IW has been on long term opioids, which is not recommended. Additionally, documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current

pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. This request is not medically necessary and reasonable.

Percocet 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: The IW has been on long term opioids, which is not recommended. Additionally, documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. This request is not medically necessary and reasonable.

Clonidine HCL 0.1mg #60 x 3 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability 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) - Catapres (clonidine) and Other Medical Treatment Guidelines uptodate.com - clonidine, Choice of drug therapy in primary (essential) hypertension: Recommendations.

Decision rationale: Per ODG guidelines there is no recommendation for clonidine's use as there is little evidence that this medication provides long-term pain relief (when used in combination with opioids approximately 80% of patients had < 24 months of pain relief) and no studies have investigated the neuromuscular, vascular or cardiovascular physiologic changes that can occur over long period of administration. Side effects include hypotension, and the medication should not be stopped abruptly due to the risk of rebound hypertension. The medication is FDA approved with an orphan drug intrathecal indication for cancer pain only. Clonidine is thought to act synergistically with opioids. Most studies on the use of this drug intrathecally for chronic non-malignant pain are limited to case reports. (Ackerman, 2003) Clonidine (Catapres) is a direct-acting adrenergic agonist prescribed historically as an antihypertensive agent, but it has found new uses, including treatment of some types of neuropathic pain. With regards to blood pressure treatment in the absence of a specific indication, there are three main classes of drugs that have been used for initial monotherapy: thiazide diuretics, long-acting calcium

channel blockers (most often a dihydropyridine), and ACE inhibitors or ARBs. The ALLHAT trial cited above included a doxazosin arm that was terminated prematurely because of a significantly increased risk of heart failure compared to chlorthalidone (relative risk 2 after adjusting for a 3 mmHg higher in-trial systolic pressure with doxazosin) noted during an interim analysis [78] and a higher rate of cardiovascular events [79]. Thus, an alpha-blocker is not recommended for initial monotherapy, with the possible exception of older men with symptoms of prostatism, particularly if they are not at high cardiovascular risk. As the prescription was noted to be for blood pressure and there was no clear indication for clonidine over one of the other classes the request is not medically necessary.

Alprazolam 0.5mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

Decision rationale: According to MTUS guidelines, 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. According to the progress notes, the IW has been using benzodiazepines for a prolonged time. This request is not medically necessary and appropriate.