MAXIMUS Federal Services

Case Number:	CM15-0138581		
Date Assigned:	07/28/2015	Date of Injury:	02/18/1990
Decision Date:	09/22/2015	UR Denial Date:	07/02/2015
Priority:	Standard	Application Received:	07/17/2015

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, Massachusetts
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:

This 58 year old female sustained an industrial injury to the neck on 2/18/90. Documentation did not disclose recent magnetic resonance imaging. Recent treatment consisted of medication management. In a follow-up report dated 6/24/15, the injured worker complained of neck pain and severe headache associated with right arm numbness and weakness. There is no mention of improvement with opioids or opioid agreement or UDS. There is also no mention of gastritis in review of systems. The injured worker stated that it was difficult to hold a steering wheel and that she could not ride a motorcycle due to weakness and decreased sensation to the right arm. Physical exam was remarkable for tenderness to palpation to the cervical spine, paraspinal musculature, trapezius and sternocleidomastoid with mildly decreased lateral rotation and lateral bending and normal upper extremity deep tendon reflexes, strength and sensation. Current diagnoses included cervical disc displacement without myelopathy, osteoarthritis, hypesthesia and muscle spasm. The treatment plan included requesting medications (Amitriptyline, Lorazepam, Lyrica, Tylenol with Codeine #3 and Omeprazole).

IMR ISSUES, DECISIONS AND RATIONALES

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

Amitriptyline 25mg #30, 3 refills: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Amitriptyline Page(s): 13.

Decision rationale: According to CA MTUS guidelines, "Recommended. Amitriptyline is a tricyclic antidepressant. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. CA MTUS guidelines states that antidepressants are "Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. (Feuerstein, 1997) (Perrot, 2006) Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. (Saarto-Cochrane, 2005)". The IW has documented evidence of neuropathic pain and has no reported adverse drug effects or medical contraindications; therefore the prescribed antidepressant is medically necessary.

Lyrica 75mg #90, 1 refill: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 16-17.

Decision rationale: According to CA MTUS "Gabapentin (Neurontin, Gabarone, generic available) has been shown to be effective for treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. (Backonja, 2002) (ICSI, 2007) (Knotkova, 2007) (Eisenberg, 2007) (Attal, 2006) This RCT concluded that gabapentin monotherapy appears to be efficacious for the treatment of pain and sleep interference associated with diabetic peripheral neuropathy and exhibits positive effects on mood and quality of life.... Recommended for neuropathic pain (pain due to nerve damage. (Gilron, 2006) (Wolfe, 2004) (Washington, 2005) (ICSI, 2005) (Wiffen-Cochrane, 2005) (Attal, 2006) (Wiffen-Cochrane, 2007) (Gilron, 2007) (ICSI, 2007) (Finnerup, 2007)." From my review of the medical records provided, the IW has objective evidence and subjective symptoms that are consistent with neuropathic pain. Based on the cited guidelines and reviewed records, continued use of gabapentin is medically necessary.

Lorazepam 1mg #180, 1 refill: 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: According to the MTUS guidelines, benzodiazepines such as the above medication 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 week. Additionally, the guidelines state that "tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety". The patient has been on this specific benzodiazepine medication for more than 4 weeks and there is no cited efficacy in the provided medical records to support continued use. Consequently, the medical records and cited guidelines do not support continued use of this medication at this time. The request is not medically necessary.

Tylenol with codeine #3, 30/300 #180, 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 76-96.

Decision rationale: CA MTUS guidelines require that criteria for continued long-term use of opioids require ongoing review and documentation of pain relief, functional status improvement, appropriate use, screening of side effects and risk for abuse, diversion and dependence. From my review of the provided medical records there is lacking a description of quantifiable improvement with ongoing long-term use of short acting opioids such as the prescribed medication. There is no VAS score reported and there is no noted improvement in objective physical exam findings or functional capacity. Consequently, continued use of short acting opioids is not medically necessary.

Omeprazole 40mg #180, 11 refills: 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 GI symptoms Page(s): 68.

Decision rationale: According to the medical records reviewed and the cited guidelines, the above medication is not clinically necessary for the following reasons: there is no evidence of medication related gastritis documented in the clinic record and the patient is not at increased risk of gastritis as risk factors including advanced age, history of peptic ulcer, gastrointestinal bleeding or concurrent use of NSAID with steroids or anticoagulants are lacking. CA MTUS guidelines state that the use of a proton pump inhibitor should be limited to the recognized indications and not prescribed for prophylactic use if there are no risk factors documented. Additionally it is recommended that it be used at the lowest dose for the shortest possible amount of time. Considering lack of documented necessity, the medication is not medically necessary at this time.