MAXIMUS Federal Services

Case Number:	CM15-0145099		
Date Assigned:	08/06/2015	Date of Injury:	05/09/2010
Decision Date:	09/17/2015	UR Denial Date:	07/16/2015
Priority:	Standard	Application Received:	07/27/2015

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: Anesthesiology

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 53-year-old female, who sustained an industrial injury on May 9, 2010. She reported right shoulder pain. The injured worker was diagnosed as having chronic right shoulder pain, tendinitis and adhesive capsulitis of the right shoulder, chronic neck pain, right upper trapezius scapular myofascial pain, degenerative disc disease of the cervical spine (non-industrial), NSAID induced gastritis secondary to long-term use of Motrin, Gastroesophageal reflux disease aggravated by industrial factors and hypertension. Treatment to date has included diagnostic studies, conservative care, and medication and work restrictions. Currently, the injured worker continued to report continued right shoulder pain and decreased range of motion. The injured worker reported an industrial injury in 2010, resulting in the above noted pain. She was treated conservatively without complete resolution of the pain. Evaluation on January 14, 2015, revealed ongoing right shoulder pain. No numerical pain scale was included in the report. Medications were continued including Norco. Evaluation on April 8, 2015, revealed continued severe right shoulder pain. She rated her pain at 9 on a 1-10 scale with 10 being the worst. She noted the pain would decrease to 8 on a 1-10 scale with the use of medications. It was noted she spends the majority of time in the bed or chair. She does not exercise and is occasionally helped out of the house by her family. It was noted she appeared to be depressed with a flat affect. It was noted she does not perform any household tasks. Magnetic resonance imaging (MRI) of the right shoulder from December 2010, revealed rotator cuff tendonitis but no tear, bursitis with partial subluxation of the biceps tendon without dislocation and impingement syndrome. Electro diagnostic studies of the upper extremities on September 7, 2011, revealed no abnormalities. Cervical spine MRI in 2010 revealed protrusion

and bulging of discs. Norco, Baclofen, Prilosec, Ambien, Lisinopril, Metoprolol, Remeron, Cymbalta and Senokot were continued. Evaluation on July 1, 2015, revealed continued pain as noted. She rated her pain at 10 on a 1-10 scale without medications and 8 on a 1-10 scale with medications, lasting for two hours. Ambien 5 mg Qty 30 with 2 refills, Baclofen 10 mg Qty 60 with 2 refills, Prilosec 20 mg Qty 60 with 2 refills, Remeron 15 mg Qty 30 with 2 refills and Ultram 50 mg Qty 90 with 2 refills were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultram 50 mg Qty 90 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Page(s): 74-96.

Decision rationale: According to the California MTUS, Tramadol (Ultram) is a synthetic opioid, which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. According to the medical records, there has been no documentation of the medication's analgesic effectiveness or functional improvement, and no clear documentation that the patient has responded to ongoing opioid therapy from one visit to the next. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic requires a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

Baclofen 10 mg Qty 60 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 64.

Decision rationale: According to the California (CA) MTUS Guidelines, Baclofen is recommended for treatment of spasticity and muscle spasms related to multiple sclerosis and spinal cord injuries. They are generally recommended for short-term treatment. There was no indication of improved pain secondary to use of Baclofen. In addition, the injured worker had used Baclofen for an extended period of time with no indication of weaning from the medication. For these reasons, Baclofen 10 mg Qty 60 with 2 refills, is not medically necessary.

Prilosec 20 mg Qty 60 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton pump inhibitors (PPIs); non-selective NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS; proton pump inhibitors Page(s): 68-69.

Decision rationale: According to the California (CA) MTUS guidelines, Prilosec, a proton pump inhibitor is appropriate for the treatment of dyspepsia secondary to NSAID use or for individuals at risk for gastrointestinal events with the use of NSAIDs. It was noted in the documentation that the injured worker experienced some gastrointestinal discomfort with the use of medications. There was no specific incident or description of gastrointestinal problems noted in the provided documents. There was no indication of continued gastrointestinal symptoms and she was no longer prescribed an NSAID. For these reasons, Prilosec 20 mg Qty 60 with 2 refills is not medically necessary.

Ambien 5 mg Qty 30 with 2 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: Pain - California sleeping medications.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Sleeping medications.

Decision rationale: California MTUS guidelines do not specifically address the use of Ambien or other non-benzodiazepine sedative drugs. According to the ODG, Zolpidem (Ambien) is a prescription short acting, non-benzodiazepine hypnotic, which is approved for short-term use (about two to six weeks), for the treatment of insomnia. Sleep aides and anti-anxiety medications are habit forming and intended for short-term use. It was not noted if the injured worker practiced good sleep hygiene. It was noted she did not exercise and remained sedentary most of all days. In addition, there were no specific goals working toward discontinuing the medication after a short-term period. Furthermore, the evaluations consistently noted poorly controlled pain with no significant improvement from one visit to the next without significant deviation in pain medications. The poor sleep was noted to be secondary to chronic pain. Ambien is noted to not be intended for the long-term treatment of chronic pain. Ambien 5 mg Qty 30 with 2 refills is not medically necessary.

Remeron 15 mg Qty 30 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Antidepressants, and SSRIs.

Decision rationale: Mirtazipine (Remeron) is FDA approved for the treatment of depression and mood disorders. It is a noradrenergic and specific serotonergic antidepressant. It is also used off label for the treatment of obsessive-compulsive disorder, social anxiety disorder, insomnia, post-traumatic stress disorder, low appetite and nausea. In this case, the documentation indicates that the patient has depression and insomnia. In this case, the injured worker did not have an improvement of symptoms during the time, which Remeron was prescribed. Medical necessity for the requested item has not been established. The requested Mirtazipine is not medically necessary.