

Case Number:	CM15-0168492		
Date Assigned:	09/09/2015	Date of Injury:	10/09/2008
Decision Date:	10/22/2015	UR Denial Date:	08/20/2015
Priority:	Standard	Application Received:	08/27/2015

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 63-year-old female who sustained an industrial injury on October 9, 2008 resulting in neck and lower back pain, and depressive-like symptoms. Diagnoses have included displacement of cervical intervertebral disc without myelopathy, brachial radiculitis, lumbosacral spondylosis without myelopathy, and depressive disorder. Documented treatment includes an epidural steroid injection on January 23, 2015, cervical discectomy and fusion February 7, 2015 which is stated to have improved radicular symptoms, and medication reducing pain by 50 percent. The injured worker continues to report headaches and neck pain, and constant low back pain. Range of motion is reduced at extremes due to pain. The treating physician's plan of care includes requested Fioricet 50 mg-300 mg-40 mg, Alprazolam 0.5 mg, Paxil 40 mg, and Zolpidem 10 mg. which were denied with due to rationale of long term use of Zolpidem and benzodiazepines not being supported; Fioricet not recommended per guidelines; and, weaning being recommended for benzodiazepines and anti-depressants. The injured worker signed a pain management agreement March 13, 2015, and urine toxicology was taken July 30, 2015 with consistent results.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fioricet 50mg -300mg-40mg #120: 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) Barbiturate-containing analgesic agents (BCAs).

Decision rationale: Barbiturate-containing analgesic agents (BCAs) are not recommended for chronic pain. The potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents. Fioricet contains Butalbital, Tylenol, and caffeine. The literature reported that Butalbital containing combination analgesics should be avoided in migraine headache management. When used, it should be closely monitored to avoid overuse and dependence. It is recommended to be used less than 10 days/month. According to the CA MTUS, all therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement. Guidelines state that only one medication should be given at a time. In this case, there is a lack of functional improvement with the treatment already provided. The treating physician did not provide sufficient evidence of improvement in the work status, activities of daily living, and dependency on continued medical care with use of Fioricet. Guidelines do not recommend BCAs for chronic pain. Medical necessity for the requested treatment has not been established. The requested medication is not medically necessary.

Alprazolam 0.5mg #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): Benzodiazepines.

Decision rationale: According to CA MTUS Guidelines, benzodiazepines are not recommended for long-term use for the treatment of chronic pain because long-term efficacy is unproven and there is a risk of dependency. Xanax (Alprazolam) is a short-acting benzodiazepine, having anxiolytic, sedative, and hypnotic properties. Most guidelines limit use of this medication to four weeks. The documentation indicates that this patient used Xanax for sleep. The MTUS does not recommend benzodiazepines for long term use for any condition. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. Medical necessity for the requested medication was not established. The requested medication was not medically necessary.

Paxil 40mg #30: Overturned

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) Antidepressants.

Decision rationale: According to the ODG, antidepressants are recommended, although not generally as a stand-alone treatment for the treatment of depression. They are recommended for the initial treatment of presentation of major depressive disorder (MDD) that are moderate, severe, or psychotic, unless electroconvulsive therapy is part of the treatment plan. Paxil (Paroxetine) is an antidepressant drug of the selective serotonin reuptake inhibitor type. It is indicated for the treatment of major depression, obsessive-compulsive disorder, panic disorder, social anxiety, post-traumatic stress disorder, generalized anxiety disorder, and vasomotor symptoms associated with menopause. In this case, the medication is part of the patient's medical regimen for the treatment of her depression. Medical necessity for the requested medication has been established. The requested medication is medically necessary.

Zolpidem 10mg #30: 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) Treatment Index 13th Edition (web) 2015 Pain (updated 07/15/2015) Zolpidem.

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

Decision rationale: Ambien (Zolpidem) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia and is rarely recommended for long-term use. It can be habit-forming, and may impair function and memory more than opioid analgesics, and may increase pain and depression over the long-term. The treatment of insomnia should be based on the etiology and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. There is no documentation of duration of prior Ambien use. There is no documentation provided indicating medical necessity for Ambien. The requested medication is not medically necessary.