

Case Number:	CM15-0193069		
Date Assigned:	10/07/2015	Date of Injury:	09/28/2013
Decision Date:	11/18/2015	UR Denial Date:	09/08/2015
Priority:	Standard	Application Received:	10/01/2015

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, Tennessee

Certification(s)/Specialty: Emergency 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 is a 44 year old male who sustained a work-related injury on 9-28-13. Medical record documentation on 8-20-15 revealed the injured worker was being treated for lumbar disc displacement without myelopathy. He presented on 8-20-15 for a medication refill. The evaluating physician noted that he had been compliant with the use of his medications. His medication regimen included gabapentin 600 mg, Naproxen sodium 550 mg, Pantoprazole 20 mg (since at least 6-5-15), Buprenorphine 0.25 mg (since at least 6-5-15), Mirtazapine 15 mg (since at least 6-5-15), Cyclobenzaprine 7.5 mg, atorvastatin 20 mg, enalapril maleate 5 mg, metformin Hcl 500 mg. Subjective and objective findings were not documented. On 7-8-2015 the injured worker received a medication refill. Subjective and objective findings were not documented. On 6-8-15 the injured worker reported continued low back pain. He reported that he could not walk for longer than 15 minutes without significant pain. His past medical history is significant for bronchitis, diabetes, myocardial infarction, and hypertension. He was status post lumbar epidural steroid injection on 3-17-15 without benefit. He had completed physical therapy and did not notice any improvement. He had massage therapy without any improvement. On 9-8-15, the Utilization Review physician determined a retrospective request for Pantoprazole 20 mg #60, Buprenorphine 0.25 mg #90, and Mirtazapine 15 mg #60 for dos 8-20-15 was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro: Pantoprazole (Protonix) 20mg #60 (DOS: 08/20/2015): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter: Proton Pump Inhibitors.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: Pantoprazole is a proton pump inhibitor (PPI). PPIs are used in the treatment of peptic ulcer disease and may be prescribed in patients who are using non-steroidal anti-inflammatory drugs and are at high-risk for gastrointestinal events. Risk factors for high-risk events are age greater than 65, history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anti-coagulant, or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The patient in this case was using NSAID medication, but did not have any of the risk factors for a gastrointestinal event. The request is not medically necessary.

Retro: Buprenorphine 0.25mg #90 (DOS: 08/20/2015): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Buprenorphine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Buprenorphine.

Decision rationale: Buprenorphine is a partial opioid agonist. It is recommended as an option for treatment of chronic pain (consensus based) in selected patients (not first-line for all patients). Suggested populations: (1) Patients with a hyperalgesic component to pain; (2) Patients with centrally mediated pain; (3) Patients with neuropathic pain; (4) Patients at high-risk of non-adherence with standard opioid maintenance; (5) For analgesia in patients who have previously been detoxified from other high-dose opioids. Use for pain with formulations other than Butrans is off-label. Due to complexity of induction and treatment the drug should be reserved for use by clinicians with experience. In this case there is no documentation that the patient belongs to any of the suggested populations. There is no documentation that the patient has failed therapy with first line medications. The request is not medically necessary.

Retro: Mirtazapine 15mg #60 (DOS: 08/20/2015): Upheld

Claims Administrator guideline: Decision based on MTUS Stress-Related Conditions 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness and Stress Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Insomnia Treatment and Other Medical Treatment Guidelines Treatment Guidelines from The Medical Letter - June 1, 2013 (Issue 130): Drugs for Psychiatric Disorders The Medical Letter on Drugs and Therapeutics, Vol 38 Issue 990, December 20, 1996, pp113-114.

Decision rationale: Mirtazapine is a tetracycline piperazinoazepine medication, used in the treatment of major depression. It increases the release of norepinephrine and serotonin. Adverse effects include transient somnolence, increased appetite, weight gain, dizziness, dry mouth and constipation. In this case the medication is requested for treatment of insomnia. Insomnia treatment should be based on etiology. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Sedating anti-depressants such as Mirtazapine have also been used to treat insomnia; however, there is less evidence to support their use for insomnia. Mirtazapine is not indicated for the treatment of insomnia. The request is not medically necessary.