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| Case Number: | CM15-0202771 | | |
| Date Assigned: | 10/19/2015 | Date of Injury: | 08/25/2010 |
| Decision Date: | 12/21/2015 | UR Denial Date: | 09/30/2015 |
| Priority: | Standard | Application Received: | 10/14/2015 |

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 44 year old male who sustained an industrial injury on 8-25-10. The injured worker reported left shoulder and back discomfort. A review of the medical records indicates that the injured worker is undergoing treatments for lumbar lumbosacral disc degeneration, sacroiliac sprain strain, adhesive capsulitis and rotator cuff injury. Medical records dated 9-23-15 indicate pain rated at 4 to 5 out of 10. Provider documentation dated 9-23-15 noted the work status as permanent and stationary. Treatment has included Norco since at least March of 2015, Psychiatrist sessions, Diazepam since at least March of 2015, Lunesta since at least March of 2015, Nortriptyline since at least March of 2015, Ultram, Xanax since at least March of 2015, status post left shoulder arthroscopy, physical therapy and home exercise program. Objective findings dated 9-23-15 were notable for lumbar spine with restricted range of motion, tenderness to palpation to paravertebral muscles and L5 bilaterally, positive straight leg raise on the right sitting at 30 degrees and on the left at 40 degrees, tenderness to palpation bilaterally to the sacroiliac joint, left shoulder with restricted range of motion in all directions. The request was for Hydrocodone-acetaminophen 10-325mg tabs SIG: 2 twice a day for pain #120, Lunesta 3 mg tabs SIG: 1 at bedtime as needed for insomnia #30, Nortriptyline HCl 50mg cap SIG: 1-2 at bedtime #60 and Xanax 2mg tabs SIG 1 twice a day #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone-acetaminophen 10/325mg tabs SIG: 2 twice a day for pain #120: Upheld

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

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

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. Additionally, this is a duplicate request for medication already approved for the IW. This request is not medically necessary and reasonable.

Lunesta 3 mg tabs SIG: 1 at bedtime as needed for insomnia #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), Mental Illness and Stress Chapter, Eszopiclone (Lunesta).

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: Per ODG pharmacological agents for insomnia should only be used after careful evaluation of potential causes of sleep disturbance for the etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Lunesta is indicated for treatment of insomnia, not recommended for long-term use, but recommended for short-term use. There is no discussion of an investigation into the origin of the sleep disturbance and non-pharmacological interventions that may have been utilized. There is notation that the IW did not respond to Ambien, Ambien CR and Sonata or that he adequately responded to Lunesta. This request is not medically necessary and appropriate.

Nortriptyline HCl 50mg cap SIG: 1-2 at bedtime #60: Upheld

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

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

Decision rationale: Tricyclic antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Side effects, including excessive sedation (especially that which would affect work performance) should be assessed. There was no notation in the documentation of neuropathy and no evidence of benefit from the tricyclic antidepressant related to decreased use of other medications, improved mood, improved level of function or assessment of possible side effects. This request is not medically necessary and appropriate.

Xanax 2mg tabs SIG 1 twice a day #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 and is still having issues with anxiety. This request is not medically necessary and appropriate.