MAXIMUS Federal Services

Case Number:	CM15-0207745		
Date Assigned:	10/26/2015	Date of Injury:	10/20/2000
Decision Date:	12/14/2015	UR Denial Date:	10/17/2015
Priority:	Standard	Application Received:	10/22/2015

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, Hawaii
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 10-20-00. The injured worker was being treated for causalgia of left upper limb and long term use of opiate analgesic. On 9-10-15 and 10-18-15, the injured worker complains of left elbow pain rated 6 out of 10 which is unchanged from previous visit; prior to Norco pain level is 7.5 out of 10 and prior to Tiagabine pain is rated 7 out of 10 with a rating of 3 out of 10 when combined with Nortriptyline and Norco. Work status is noted to be modified duty. Physical exam performed on 9-10-15 and 10-18-15 revealed left arm in ace wrap and injured worker is rubbing the arm. Urine drug screen performed on 10-18-15 was consistent with medications prescribed. Treatment to date has included oral medications including Tiagabine (since at least 2001), Neurontin, Norco, Effexor, Gabitril and Acetaminophen; topical Lidoderm patch; elbow brace and activity modifications. The treatment plan included trial of Trazodone, samples of Lyrica, continuation of Effexor and urgent request for Tiagabine. On 10-17-15 request for Trazodone 50mg #30 with 1 refill and unknown prescription of Tiagabine was non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazodone 50 mg Qty 30 with 1 refill: 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 - Insomnia medication.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain, Insomnia Treatment.

Decision rationale: The patient presents with pain affecting the left upper limb. The current request is for Trazodone 50 mg Qty 30 with 1 refill. The treating physician report dated 10/8/15 (218B) states, trial of trazodone for periodic sleep aid. The Trazodone HCL 100 mg (2 tablets at hour of sleep as needed for sleep) #60. MTUS and ACOEM are silent on this medication. ODG states the following on Trazodone (Desyrel), Recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. See also Insomnia treatment, where it says there is limited evidence to support its use for insomnia, but it may be an option in patients with coexisting depression. In this case, while the report dated 10/8/15 notes that the patient requires a sleep aide twice a month, there is no documentation that the patient suffers from chronic Insomnia. Furthermore, while a small trial may be reasonable, the current request for one refill without documentation of functional improvement is excessive and not supported. The current request is not medically necessary.

Tiagabine, unknown prescription: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: The patient presents with pain affecting the left upper limb. The current request is for Tiagabine, unknown prescription. The treating physician report dated 10/8/15 (226B) states, "She has been on tiagabine for many years and able to function." The MTUS guidelines state the following: Levetiracetam (Keppra, no generic), Zonisamide (Zonegran, no generic), and Tiagabine (Gabitril, no generic), are among the antiepileptic drugs (AEDs) most recently approved, while these drugs may be effective for neuropathic pain, the ultimate role of these agents for pain requires further research and experience. In this case, while the current request may be medically necessary, there is no quantity or strength of Tiagabine specified in the current request and the MTUS guidelines do not support an open ended request. The current request is not medically necessary.