

Case Number:	CM15-0067819		
Date Assigned:	04/15/2015	Date of Injury:	05/18/2010
Decision Date:	07/09/2015	UR Denial Date:	03/25/2015
Priority:	Standard	Application Received:	04/09/2015

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
 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 59 year old female, who sustained an industrial injury on 5/18/2010. She reported low back pain. Diagnoses have included low back pain, lumbar/lumbosacral disc degeneration and radiculopathy. Treatment to date has included lumbar surgery, physical therapy and medication. According to the progress report dated 3/4/2015, the injured worker complained of low back pain radiating down both legs. She reported that her pain level had increased since the last visit. She rated her pain with medications as 4/10. Pain without medications was rated 5/10. Lumbar spine range of motion was restricted. There was tenderness to palpation of the lumbar paravertebral muscles. Authorization was requested for Tylenol ES, Colace, Trazadone, Abilify and Ibuprofen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tylenol Ex-str 500mg, #90, 1 refill: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Medications for chronic pain Page(s): 22, 60.

Decision rationale: The patient presents with back pain radiating to lower extremities rated 4/10 with and 5/10 without medications. The request is for TYLENOL EX-STR 500MG, #90, 1 REFILL. The request for authorization is dated 03/17/15. Patient is status-post L2-3, L3-4 and L4-5 decompression, 05/19/14. Physical examination of the lumbar spine reveals tenderness to palpation over the paravertebral muscles on both sides. Range of motion is restricted. According to patient medications are working well. She still has pain symptoms on a continuous basis, but they are alleviated somewhat by current meds. Patient's medications include Colace, Trazodone, Abilify, Gabapentin, Ibuprofen and Tylenol. Per progress report dated 03/04/15, the patient is permanent and stationary. MTUS Chronic Pain Medical Treatment Guidelines, pg 22 for Anti-inflammatory medications states: Anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. A comprehensive review of clinical trials on the efficacy and safety of drugs for the treatment of low back pain concludes that available evidence supports the effectiveness of non-selective nonsteroidal anti-inflammatory drugs (NSAIDs) in chronic LBP and of antidepressants in chronic LBP. MTUS p60 also states, "A record of pain and function with the medication should be recorded," when medications are used for chronic pain. Treater does not specifically discuss this medication. The patient is prescribed Tylenol since at least 02/04/15. The patient continues with low back pain. The treater has adequately documented decreased in pain and increase in function. Therefore, the request IS medically necessary.

Colace 100mg, #60, 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Therapeutic Trial of Opioids Page(s): 77.

Decision rationale: The patient presents with back pain radiating to lower extremities rated 4/10 with and 5/10 without medications. The request is for COLACE 100MG, #60, 3 REFILLS. The request for authorization is dated 03/17/15. Patient is status-post L2-3, L3-4 and L4-5 decompression, 05/19/14. Physical examination of the lumbar spine reveals tenderness to palpation over the paravertebral muscles on both sides. Range of motion is restricted. According to patient medications are working well. She still has pain symptoms on a continuous basis, but they are alleviated somewhat by current meds. Patient's medications include Colace, Trazodone, Abilify, Gabapentin, Ibuprofen and Tylenol. Per progress report dated 03/04/15, the patient is permanent and stationary. MTUS Chronic Pain Medical Treatment Guidelines, page 77, Under the heading: Therapeutic Trial of Opioids state that "... Prophylactic treatment of constipation should be initiated." Treater does not specifically discuss this medication. MTUS Guidelines allows for prophylactic use of medication for constipation when opiates are taken. However, current list of medication prescribed to patient do not include any opiates. Therefore, the request IS NOT medically necessary.

Trazodone 100mg, #30, 3 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Medications for chronic pain Page(s): 13-15, 60. Decision based on Non-MTUS Citation Official disability guidelines Pain Chapter, under Insomnia has the following regarding Amitriptyline.

Decision rationale: The patient presents with back pain radiating to lower extremities rated 4/10 with and 5/10 without medications. The request is for TRAZODONE 100MG, #30, 3 REFILLS. The request for authorization is dated 03/17/15. Patient is status-post L2-3, L3-4 and L4-5 decompression, 05/19/14. Physical examination of the lumbar spine reveals tenderness to palpation over the paravertebral muscles on both sides. Range of motion is restricted. According to patient medications are working well. She still has pain symptoms on a continuous basis, but they are alleviated somewhat by current meds. Patient's medications include Colace, Trazodone, Abilify, Gabapentin, Ibuprofen and Tylenol. Per progress report dated 03/04/15, the patient is permanent and stationary. Regarding anti-depressants, MTUS Guidelines, page 13-15, CHRONIC PAIN MEDICAL TREATMENT GUIDELINES: Antidepressants for chronic pain states: "Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. (Feuerstein, 1997) (Perrot, 2006) Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur." MTUS page 60 requires documentation of pain assessment and functional changes when medications are used for chronic pain. ODG guidelines Pain Chapter, under Insomnia has the following regarding Amitriptyline: Sedating antidepressants (e.g., amitriptyline, trazodone, mirtazapine) have also been used to treat insomnia; however, there is less evidence to support their use for insomnia (Buscemi, 2007) (Morin, 2007), but they may be an option in patients with coexisting depression. Per progress report dated, 03/04/15, treater's reason for the request is "sleep." The patient is prescribed Trazodone since at least 04/08/14. MTUS page 60 require that medication efficacy in terms of pain reduction and functional gains must be discussed when using for chronic pain. The patient continues with low back pain. The treater has adequately documented decreased in pain and increase in function. Therefore, the request IS medically necessary.

Abilify 5mg, #30, 3 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 (ODG) Mental Illness & Stress.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Mental Illness & Stress Chapter, Aripiprazole (Abilify).

Decision rationale: The patient presents with back pain radiating to lower extremities rated 4/10 with and 5/10 without medications. The request is for ABILIFY 5MG, #30, 3 REFILLS. The request for authorization is dated 03/17/15. Patient is status-post L2-3, L3-4 and L4-5 decompression, 05/19/14. Physical examination of the lumbar spine reveals tenderness to palpation over the paravertebral muscles on both sides. Range of motion is restricted. According to patient medications are working well. She still has pain symptoms on a continuous basis, but they are alleviated somewhat by current meds. Patient's medications include Colace, Trazodone, Abilify, Gabapentin, Ibuprofen and Tylenol. Per progress report dated 03/04/15, the patient is permanent and stationary. ODG-TWC, Mental Illness & Stress Chapter, Aripiprazole (Abilify) Section states: "Not recommended as a first-line treatment. Abilify(aripiprazole) is an antipsychotic medication. Antipsychotics are the first-line psychiatric treatment for schizophrenia. There is insufficient evidence to recommend atypical antipsychotics for conditions covered in ODG." Per progress report dated, 03/04/15, treater's reason for the request is "for mood." Patient has been prescribed Abilify since at least 04/08/14. ODG guidelines do not recommend Abilify as first-line treatment, since "there is insufficient evidence to recommend atypical antipsychotics for conditions covered in ODG." Therefore, the request IS NOT medically necessary.

Ibuprofen 600mg, #60, 3 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Medications for chronic pain Page(s): 22, 60.

Decision rationale: The patient presents with back pain radiating to lower extremities rated 4/10 with and 5/10 without medications. The request is for IBUPROFEN 600MG, #60, 3 REFILLS. The request for authorization is dated 03/17/15. Patient is status-post L2-3, L3-4 and L4-5 decompression, 05/19/14. Physical examination of the lumbar spine reveals tenderness to palpation over the paravertebral muscles on both sides. Range of motion is restricted. According to patient medications are working well. She still has pain symptoms on a continuous basis, but they are alleviated somewhat by current meds. Patient's medications include Colace, Trazodone, Abilify, Gabapentin, Ibuprofen and Tylenol. Per progress report dated 03/04/15, the patient is permanent and stationary. MTUS Chronic Pain Medical Treatment Guidelines, pg 22 for Anti-inflammatory medications states: Anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. A comprehensive review of clinical trials on the efficacy and safety of drugs for the treatment of low back pain concludes that available evidence supports the effectiveness of non-selective non-steroidal anti-inflammatory drugs (NSAIDs) in chronic LBP and of antidepressants in chronic LBP. MTUS p60 also states, "A record of pain and function with the medication should be recorded," when medications are used for chronic pain. Treater does not specifically discuss this medication. The patient is prescribed Ibuprofen since at least 04/08/14. The patient continues with low back pain. The treater has adequately documented decreased in pain and increase in function. Therefore, the request IS medically necessary.