

Case Number:	CM15-0081228		
Date Assigned:	05/01/2015	Date of Injury:	12/14/2002
Decision Date:	06/25/2015	UR Denial Date:	04/16/2015
Priority:	Standard	Application Received:	04/28/2015

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 53 year old male, who sustained an industrial/work injury on 12/14/02. He reported initial complaints of left knee pain. The injured worker was diagnosed as having bilateral knee pain. Treatment to date has included medication, surgery (bilateral knee replacements in 2008-2011 and revisions in 7/2013), psychiatry care, and epidural steroid injection to lumbar region. Currently, the injured worker complains of bilateral knee pain. Per the primary physician's progress report (PR-2) on 3/17/15, examination of the right knee noted tenderness to the medial side, lateral side, painful knee flexion, medial and lateral joint line tenderness. The left knee had edema, effusion, tenderness over the medial and lateral side, medial joint tenderness, and painful flexion. The lumbar area had trigger points to sciatic areas, iliac crest lumbar paraspinals, reduced range of motion by 50%, reduced sensation in the foot, abnormal motor exam, and abnormal reduced ankle jerk, and abnormal gait. Current plan of care included conservative treatments, ultrasound guided caudal epidural injection for spine, and medications. The requested treatments include Buspar, Lyrica, Edular, Lansoprazole, Tranxene T-tab, and Paxil.

IMR ISSUES, DECISIONS AND RATIONALES

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

Buspar 15mg #60: Overturned

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

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

Decision rationale: Buspar (Buspirone) is a 5-HT_{1A} agonist that is approved for short-term relief of anxiety symptoms. Efficacy is decreased in patients with recent prior benzodiazepine use. In this case, the patient has been receiving psychiatric care services and has also been prescribed an antidepressant. Buspar is part of his medical regimen. The medical necessity for Buspar has been established. The requested medical is medically necessary.

Lyrica 150mg #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 Treatment Guidelines Lyrica Page(s): 58.

Decision rationale: According to California MTUS Guidelines, anti-epilepsy medications are a first-line treatment for neuropathic pain. Lyrica is FDA approved for diabetic neuropathy and post-herpetic neuralgia and has been used effectively for the treatment of other neuropathic pain. A good response to therapy with this medication is described as a 50% reduction in complaints of neuropathic pain. In this case, this patient has low back pain (LBP) without documentation of neuropathic pain. Lyrica has been used in the past however, there is no documentation that guidelines have been met. Medical necessity for the requested medication has not been established. The requested item is not medically necessary.

Edular 10mg #30: Upheld

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

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: Edular (Zolpidem sub-lingual) 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 Edular use. There is no documentation provided indicating medical necessity for Edular. The requested medication is not medically necessary.

Lansoprazole 30mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPIs Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

Decision rationale: According to the CA MTUS, proton pump inhibitors, such as Lansoprazole (Prevacid), are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. There is no documentation indicating the patient has any GI symptoms or GI risk factors. Medical necessity for Lansoprazole has not been established. The requested medication is not medically necessary.

Tranxene T-tab 7.5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines. Decision based on Non-MTUS Citation <http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682052.html>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Benzodiazepines.

Decision rationale: According to CA MTUS guidelines, benzodiazepines are prescribed for anxiety. They 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. Tranxene (Clorazepate) is a benzodiazepine, having anxiolytic, sedative, muscle relaxant, anticonvulsant, and hypnotic properties. Most guidelines recommend the use of Tranxene for the treatment of anxiety disorders, and as an adjunct treatment for anxiety associated with major depression. Use of this medication is limited to four weeks. There is no documentation of a rationale for continuing the use of this medication. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Paxil 20mg #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 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) 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 has been part of the patient's medical regimen for the treatment of his depression. Medical necessity for the requested medication has been established. The requested medication is medically necessary.