

Case Number:	CM14-0118304		
Date Assigned:	08/06/2014	Date of Injury:	04/11/2008
Decision Date:	10/14/2014	UR Denial Date:	06/26/2014
Priority:	Standard	Application Received:	07/25/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 records presented for review indicate that this 61 year-old female was reportedly injured on April 11, 2008. The most recent progress note, dated March 20, 2014, indicates that there were ongoing complaints of neck and shoulder pain. The physical examination was not reported. Diagnostic imaging studies objectified were not reported. Previous treatment includes cervical fusion, multiple medications, a functional restoration protocol, physical therapy, and other pain management interventions. A request had been made for multiple medications and was not certified in the pre-authorization process on June 26, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lexapro 10mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16, 107.

Decision rationale: Selective Serotonin Reuptake Inhibitors (SSRIs) are a class of antidepressants that inhibit serotonin reuptake without action on noradrenaline. They have not shown to be effective for low back pain, however, it has been suggested that they have a role in

addressing psychological symptoms associated with chronic pain. MTUS guidelines support the use of SSRIs, and Zoloft, for neuropathic pain after failure to a first-line agent (Tricyclic Antidepressants). Review of the available medical records, fails to document a trial and/or failure to first-line agents. There is a dearth of information noted in the progress notes reviewed. As such, this request is not medically necessary.

Lunesta 2mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Med Lett Drugs Ther

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, updated October, 2014

Decision rationale: It is noted that this medication is not addressed in the MTUS or the ACOEM guidelines. However, the ODG does support the use of this for short-term and no more than 4 weeks. This is not indicated for chronic, indefinite, or long-term use. Therefore, based on the rather scant progress notes presented for review, there is no data presented to suggest that the guidelines be obviated. As such, the medical necessity cannot be established.

Lyrica 75mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 19, 99.

Decision rationale: This medication has been documented be effective the treatment of diabetic neuropathy and post-herpetic neuralgia. There is some indication for off label use in low back pain. However, what is not noted is any efficacy or utility in terms of increased pain control or increased functionality with uses medication. As such, there is no medical necessity provided in these progress notes to support the continued use of this medication.

Mirapex 0.25mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Consult

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Earley, Christopher J. (2003). "Restless Legs Syndrome". New England Journal of Medicine 348 (21): 2103-9.

Decision rationale: This medication is indicated for the treatment of restless leg syndrome (a.k.a. Willis Ekbohm disease). This disease process is not addressed in the MTUS, ACOEM or

ODG. A literature search was conducted. The medication has some indication in the treatment of this diagnosis. However, there is actually no clinical data presented in the progress notes reviewed to support the clinical indication or the efficacy in the use of this medication. Therefore, given the complete lack of clinical information the medical necessity cannot be established.

Protonix 20mg #60: 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)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: This is a protein pump inhibitor useful for the treatment of gastroesophageal reflux disease and can be considered a gastric protectorate for those individuals utilizing non-steroidal medications. There is nothing in the progress notes about a history of gastrointestinal distress. However, there is a handwritten note from the injured employee indicating a history of ulcer. Unfortunately, without objectification this becomes a subjective parameter and not the competent, objective, and independently confirmable medical evidence necessary to support the medical necessity of this intervention. Therefore, based on the medical records presented for review this is not medically necessary.