

Case Number:	CM14-0146058		
Date Assigned:	09/12/2014	Date of Injury:	01/30/2002
Decision Date:	10/14/2014	UR Denial Date:	08/18/2014
Priority:	Standard	Application Received:	09/09/2014

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 California. 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 patient is a 61-year-old female who has submitted a claim for CRPS associated with an industrial injury date of 01/30/2002. Medical records from 01/08/2014 to 08/19/2014 were reviewed and showed that patient complained of left arm and shoulder pain graded 5-6/10. Physical examination revealed decreased left shoulder ROM, weakness of left hand, decreased sensation over anterior aspect of left upper extremity, and allodynia of left arm. MRI of the left shoulder dated 08/19/2014 revealed AC joint degenerative changes, partial thickness tear of distal supraspinatus tendon, supraspinatus and infraspinatus tendinosis, and minimal joint effusion. Of note, there was no evaluation of function, sleep quality and duration, and psychological assessment. Treatment to date has included Lorazepam 1mg #60 (prescribed 01/08/2014), Norco 10/325mg #120 (prescribed 01/08/2014), Amitriptyline 50mg (quantity not specified; prescribed 07/09/2014), Toradol injection with vitamin B (03/19/2014), Methadone HCl 10mg (quantity not specified; DOS; 08/18/2014), and physical therapy. Of note, patient reported pain scale grade reduction from 6 to 5 with oral medications. It was not specified as to which pain medications provided relief. There was no documentation of functional outcome with Lorazepam use. Utilization review dated 08/18/2014 denied the request for Lorazepam 1mg quantity: 60.00 because there was no documentation of derived symptomatic or functional improvement from its use. Utilization review dated 08/18/2014 denied the request for amitriptyline 50mg quantity: 60.00 because there was insufficient documentation to indicate additional authorization. Utilization review dated 08/18/2014 modified the request for Methadone HCl 10mg quantity: 120.00 to quantity 30 for the purpose of weaning.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription for lorazepam 1mg QTY: 60.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines BENZODIAZEPINES Page(s): 24.

Decision rationale: According to CA MTUS Chronic Pain treatment 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. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Tolerance to hypnotic effects develops rapidly. In this case, the patient was prescribed Lorazepam 1mg #60 since 01/08/2014. However, there was no documentation of functional improvement with prior Lorazepam use. The long-term use of Lorazepam is not in conjunction with guidelines recommendation for use of benzodiazepines. Therefore, the request for lorazepam 1mg QTY: 60.00 is not medically necessary.

1 prescription for methadone HCL 10 mg QTY: 120.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines METHADONE; OPIOIDS Page(s): 61-68; 78.

Decision rationale: According to page 78 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that ongoing opioid treatment should include monitoring of analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors; these outcomes over time should affect the therapeutic decisions for continuation. There was no documentation of pain relief, functional improvement, and recent urine toxicology review, which are required to support continued use of opiates. The California MTUS on pages 61-62 also indicate that methadone is recommended as a second line drug for moderate to severe pain if the potential benefit outweighs the risk. In this case, the patient was prescribed Methadone HCL 10mg (quantity not specified) since 08/18/2014. The patient has been initially prescribed Norco 10/325mg #120 since 01/08/2014. There was documentation of pain relief with use of pain medications. However, it is unclear as to whether pain relief was derived from opioids use or other pain medications. The guidelines only recommend continuation of opioids use provided there is objective documentation of pain relief or functional improvement. Based on the medical records, the medical necessity cannot be established due to insufficient information. Therefore, the request for 1 prescription for methadone HCL 10 mg QTY: 120.00 is not medically necessary.

1 prescription for Amitriptyline HCL 50mg QTY: 60.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIDEPRESSANTS FOR CHRONIC PAIN; AMITRIPTYLINE Page(s): 13-14; 13.

Decision rationale: As stated on page 13 of the CA MTUS Chronic Pain Medical Treatment Guidelines, amitriptyline is a tricyclic antidepressant and is generally considered a first-line agent unless ineffective, poorly tolerated, or contraindicated. Tricyclic antidepressants are recommended as a first-line option, especially if pain is accompanied by insomnia, anxiety, or depression. 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. In this case, the patient was prescribed Amitriptyline 50mg (quantity not specified) since 07/09/2014. There was documentation of pain relief with pain medications. However, there was no evaluation of function, sleep quality and duration, and psychological assessment to support the use of Amitriptyline. The medical necessity cannot be established due to insufficient information. Therefore, the request for 1 prescription for Amitriptyline HCL 50mg QTY: 60.00 is not medically necessary.