

Case Number:	CM14-0161197		
Date Assigned:	10/06/2014	Date of Injury:	08/10/1993
Decision Date:	10/30/2014	UR Denial Date:	09/15/2014
Priority:	Standard	Application Received:	10/01/2014

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 Texas. 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:

Medical records reflect the claimant is a 53 year old male who sustained a work injury on 8-1-93. Office visit on 8-13-14 notes the claimant reports his left ankle pain has decrease. His pain is 3/5 with medications. Continues with home exercise program. There is a request for CT of the left ankle to rule out fracture of talus. Orthotics requested. Office visit on 8-29-14 notes the claimant has increased on in the neck with radicular symptoms to both upper extremities, numbness in both hands. The claimant had an epidural steroid injection on 7-21-14 with 60% benefit. He has left ankle pain. On exam, the claimant has tenderness to palpation at the cervical and lumbar spine with decreased range of motion, muscle rigidity. He has decreased sensation at the lateral arm and forearm bilaterally. He has decreased sensation at the L5 distribution bilaterally. SLR positive at 60 degrees on the right and 45 degrees on the left. He has pain at the right knee at medial and lateral joint line with crepitus noted with range of motion. Left ankle shows obvious swelling, clean, well healed surgical scar.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zanaflex 4mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain), Antispasticity/antispasmodic drugs Pa.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines muscle relaxants Page(s): 63-67. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter - muscle relaxants

Decision rationale: Chronic Pain Medical Treatment Guidelines as well as ODG does not support the long term use of muscle relaxants. There are no extenuating circumstances to support the long term use of this medication in this case. There is an absence in documentation noting muscle spasms. Therefore, the medical necessity of this request is not established.

Trazadone 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazapines Page(s): 24.

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

Decision rationale: ODG reflect that Trazodone is 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. See also Fibromyalgia in the Pain Chapter, where Trazodone was used successfully in fibromyalgia. Trazodone was approved in 1982 for the treatment of depression. It is unrelated to tricyclic or tetracyclic antidepressants and has some action as an anxiolytic. Off-label uses include alcoholism, anxiety, insomnia, and panic disorder. Although approved to treat depression, the American Psychiatric Association notes that it is not typically used for major depressive disorder. Over the period 1987 through 1996, prescribing Trazodone for depression decreased throughout the decade, while off-label use of the drug for insomnia increased steadily until it was the most frequently prescribed insomnia agent. There is an absence in documentation noting that this claimant has insomnia, failed first line of treatment or the need for this medication with objective documentation of anxiety and depression. Therefore, the medical necessity of this medication is not established.

Lexapro 10mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazapines Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines anti-depressants Page(s): pages 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter - anti depressants

Decision rationale: Chronic Pain Medical Treatment Guidelines reflect that anti-depressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. ODG notes that Selective serotonin reuptake inhibitors (SSRIs), a class of antidepressants that inhibit serotonin reuptake without action on noradrenaline, are controversial based on

controlled trials. (Finnerup, 2005) (Saarto-Cochrane, 2005) It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain. There is no documentation of psychological diagnostic results noting objective findings of depression. Therefore, the medical necessity of this request is not established.

Xanax 1mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazapines Page(s): 24.

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

Decision rationale: Chronic Pain Medical Treatment Guidelines as well as ODG reflect that 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. There is an absence in documentation noting that this claimant has a diagnosis or a condition that would support exceeding current treatment guidelines or that there are extenuating circumstances to support the long term use of this medication. Therefore, the medical necessity of this request is not established.