

Case Number:	CM14-0087942		
Date Assigned:	07/23/2014	Date of Injury:	07/17/2002
Decision Date:	06/26/2015	UR Denial Date:	05/20/2014
Priority:	Standard	Application Received:	06/11/2014

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. 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 44-year-old, male who sustained a work related injury on 7/17/02. The diagnoses have included depression, status post lumbar fusion, chronic low back pain, multilevel lumbar degenerative disc disease and chronic muscle spasms. The treatments have included medications, home exercises and TENS unit therapy. In the PR-2 dated 5/14/14, the injured worker complains of mid to low back pain. He has pain and some numbness and tingling down both legs. He has an average pain level of 3-4/10. He rates his pain a 3/10 with medications and a 6/10 without medications. He states pain is improved with pain medications. He is able to do some activities of daily living. The treatment plan is refills of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg, #90 with three (3) refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the CA MTUS and ODG, Norco 10/325mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is documentation of the medication's functional benefit. However, based on the number of refills (3) requested in addition to the prescription, this opioid does not meet the criteria for long term opioids as elaborated in the MTUS. This does not imply that some form of analgesia is contraindicated; only that the opioids as prescribed have not been prescribed according to the MTUS and that the results of use do not meet the requirements of the MTUS. However, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

Ativan 0.5mg, #60 with three (3) refills: Upheld

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

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 the 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. Ativan (Lorazepam) is a long-acting benzodiazepine, having anxiolytic, sedative, muscle relaxant, anticonvulsant, and hypnotic properties. Most guidelines recommend the use of Ativan 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. This medication was requested along with 3 refills. This has not been prescribed according to the MTUS. The requested medication is not medically necessary.

Senokot #60 with three (3) refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guidelines Clearinghouse.

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

Decision rationale: Opioid-induced constipation is a common adverse effect of long-term opioid use because of the binding of opioids to peripheral opioid receptors in the gastrointestinal tract, resulting in absorption of electrolytes and reduction in small intestine fluid. Senokot is a stimulant laxative and is used to relieve occasional constipation. According to ODG, if opioids are determined to be appropriate for the treatment of pain then prophylactic treatment of constipation should be initiated. In this case, with non-approval of opioid use, the medical necessity of Senokot has not been established. The requested medication is not medically necessary.

Trazodone 50mg, #30 with three (3) refills: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 388, 402. Decision based on Non-MTUS Citation 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 (ODG) Insomnia treatment.

Decision rationale: Trazodone (Desyrel) is recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. It is unrelated to tricyclic or tetracyclic antidepressants and has some action as an anxiolytic. In this case, there is documentation of a history of depression and insomnia. However, a positive response should be seen prior to prescribing (3) refills. There should also be a specialty referral, as well. Medical necessity for the requested medication, with 3 refills, has not been established. The requested medication, with 3 refills, is medically necessary.

Cymbalta 30mg, #30 with three (3) refills: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 388, 402. Decision based on Non-MTUS Citation ODG, Mental Illness & Stress.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants, SNRIs Page(s): 13, 15-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cymbalta Antidepressants for chronic pain.

Decision rationale: According to the California MTUS Guidelines, antidepressants are indicated for the treatment of chronic musculoskeletal pain. They are recommended as a first-line option for neuropathic pain, and as a possibility for non-neuropathic pain. Cymbalta (Duloxetine) is a norepinephrine and serotonin reuptake inhibitor antidepressant (SNRI). It has FDA approval for treatment of depression, generalized anxiety disorder, and for the treatment of pain related to diabetic neuropathy. In this case, there is a reported response to Cymbalta use. Therefore, continuation at the current dose is appropriate. Medical necessity for the requested medication has been established. The requested medication is medically necessary.