

Case Number:	CM15-0120624		
Date Assigned:	07/07/2015	Date of Injury:	09/17/1993
Decision Date:	09/17/2015	UR Denial Date:	06/09/2015
Priority:	Standard	Application Received:	06/22/2015

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: Emergency Medicine

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 67 year old male, who sustained an industrial injury on 09/17/1993. He has reported subsequent low back pain radiating to the lower extremity and was diagnosed with low back pain and spinal/lumbar degenerative disc disease. The injured worker was also diagnosed with an unspecified mood disorder. MRI of the lumbar spine dated 09/05/2012 showed anterolisthesis of L2 on L3 and stenosis of the spinal canal, left far lateral extraforaminal L3-L4 disc protrusion and tear of the annulus fibrosus and anterolisthesis of L5 on S1 with bilateral spondylolysis. Treatment to date has included oral and topical pain medication. Documentation shows that Lexapro, Valium, Duragesic and Percocet had been prescribed to the injured worker since at least 12/18/2014. The most recent progress notes dated 04/02/2015, 04/30/2015 and 05/28/2015, reported injured worker's pain as 6-7/10 with either no change or a decrease in activity levels. Objective findings were notable for a wide based antalgic gait, restricted range of motion of the lumbar spine, tenderness to palpation of the paravertebral muscles, positive straight leg raise on the left side at 50 degrees, decreased motor strength of the ankle dorsi and plantar flexor's on the left and decreased sensation to light touch over the lateral foot, medial foot and lateral calf on the left side. Work status was listed as permanent and stationary and the injured worker remained off work. A request for authorization of Lexapro 20 mg #30 with 1 refill, Valium 5 mg #30 with 1 refill, Duragesic 75 mcg/hr patch #15 with 1 refill and Percocet 10/325 mg #180 with 1 refill was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lexapro 20mg #30 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SSRIs, (selective serotonin reuptake inhibitors) Page(s): 107.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress, Escitalopram (Lexapro).

Decision rationale: As per CA MTUS guidelines, anti-depressants are recommended as a first line option for neuropathic pain and possibly non-neuropathic pain. Documentation should include an assessment of pain outcomes, evaluation of function, sleep quality and a psychological assessment. As per MTUS, selective serotonin reuptake inhibitors (SSRI's) have not been shown to be effective for low back pain and there is no high quality evidence to support the use of specific anti-depressants for treatment of lumbosacral radiculopathy. As per ODG guidelines, Lexapro is recommended as a first line treatment option for major depressive disorder and post-traumatic stress disorder. The documentation submitted shows that Lexapro had been prescribed to the injured worker since at least 12/18/2014. There was no indication as to why this medication was prescribed. A diagnosis of mood disorder was listed but there was no specification as to which mood disorder was diagnosed. In addition, there are no psychological assessment findings documented. There is no evidence of significant objective functional improvement/symptom reduction as indicated by no change in work status, unchanged pain levels and either unchanged or decreased activity levels despite medication use. Therefore, the request for authorization of Lexapro 20 mg #30 with 1 refill is not medically necessary.

Valium 5mg #30 with 1 refill: 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 rationale: As per CA MTUS guidelines, benzodiazepines are not recommended for long term use due to the absence of evidence for long term efficacy and risk of dependence and most guidelines limit use to 4 weeks. MTUS further indicates that a more appropriate treatment for anxiety disorder is an anti-depressant. The documentation submitted shows that Valium had been prescribed to the injured worker since at least 12/18/2014. There was no indication as to why this medication was prescribed. A diagnosis of mood disorder was listed but there was no specification as to which mood disorder was diagnosed. In addition, there are no psychological assessment findings documented. In addition, guidelines do not recommend benzodiazepines for long term use. Therefore, the request for authorization of Valium 5 mg #30 with 1 refill is not medically necessary.

Duragesic 75mcg/hr patch #15 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: According to CAMTUS, Fentanyl is a long-acting narcotic analgesic used to manage both acute and chronic pain. Fentanyl is an opioid analgesic with a potency of eighty times that of Morphine. Fentanyl transdermal (Duragesic) patches are indicated for the management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy. Duragesic patches should only be used in patients who are currently on opioid therapy for which tolerance has developed. Patches are worn for a 72-hour period. In this case, 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. There is no documentation of the most and least amount of pain, average pain, intensity of pain after opioid use and duration of pain relief. The documentation submitted shows that Duragesic patches had been prescribed to the injured worker since at least 12/18/2014. There is no evidence of significant objective functional improvement/symptom reduction as indicated by no change in work status, unchanged pain levels and either unchanged or decreased activity levels despite medication use. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper to avoid withdrawal symptoms. Therefore, the request for authorization of Duragesic 75 mcg/hr patch #15 with 1 refill is not medically necessary.

Percocet 10/325mg #180 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: According to the CA MTUS, Percocet (Oxycodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to 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. There is no documentation of the most and least amount of pain, average pain, intensity of pain after opioid use and duration of pain relief. The documentation submitted shows that Percocet had been prescribed to the injured worker since at least 12/18/2014. There is no evidence of significant objective functional improvement/symptom reduction as indicated by no change in work status, unchanged pain levels and either unchanged or decreased activity levels despite medication use. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper to avoid withdrawal symptoms. Therefore, the request for authorization of Percocet 10/325 mg #180 with 1 refill is not medically necessary.