

Case Number:	CM15-0027609		
Date Assigned:	02/19/2015	Date of Injury:	01/12/1999
Decision Date:	04/03/2015	UR Denial Date:	02/02/2015
Priority:	Standard	Application Received:	02/13/2015

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 Jersey, New York
 Certification(s)/Specialty: Family Practice

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 52 year old male, who sustained an industrial injury reported on 1/12/1999. He reported worsening anxiety after, previously, continuing effective medication therapy and abruptly discontinuing regular psychotherapy. The history notes complaints of leg and low back pain, with bilateral lumbar 3-4 and lumbar 5 radiofrequency neurotomy (12/9/14), with 50-60% reduction in axial back pain, repeat caudal epidural injection on 12/16/14 with 80% reduction in coccyx pain/symptoms; and bilateral radiofrequency ablation at lumbar 4-5 and lumbar 5-sacral 1 in the facet joint (3/20/14) with 80% reduction in lower back pain. The diagnoses were noted to have included displacement of thoracic or lumbar intervertebral disc without myelopathy; thoracic or lumbosacral neuritis or radiculitis; lumbosacral sprain/strain, with spondylosis without myelopathy; lumbago; pain disorder related to psychological factors; non-dependent abuse of drugs - completely weaned from Butrans patch; physiological malfunction arising from mental factors; major depressive disorder-recurrent episodes - severe and without mention of psychotic episode; and unspecified insomnia; Treatments to date have included multiple consultations; diagnostic imaging studies; psychological therapy; physical therapy; hand physical therapy; activity/exercise; functional restoration follow-up; and medication management. The work status classification for this injured worker (IW) was not noted. The 1/13/2015 psychiatric progress notes describe the demeanor of the IW to be mildly agitated, with intense affect, a frustrated mood and nervous. On 2/2/2015, Utilization Review (UR) non-certified, for medical necessity, the request, made on 1/13/2015, for Abilify 2 mg, #30 with 5 refills (or 30 per month for 6 months); Duloxetine 80mg, 60 per month for at least 12

months (un-specified frequency); Generic Lunesta 3mg, 60 per month for at least 12 months (unspecified frequency), all to treat major depressive disorder and pain disorder. The Medical Treatment Utilization Schedule, title 8, and the American College of Occupational and Environmental Medicine; and the Official Disability Guidelines, chronic pain, work loss data institute - mental illness and stress section, as cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

3 Abilify 2 mg 30 per month for 6 months: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Aripiprazole, Mental/Stress.

Decision rationale: MTUS guidelines do not address the use of Abilify. The patient was started on Abilify in addition to his Cymbalta to improve depression symptoms. With Abilify, he had decreased depressive symptoms, improved sleep, more energy, and a brighter outlook. According to ODG, Abilify can be used as adjunct second-line therapy for d major depressive disorder which the patient suffered from. The patient also had psychotherapy sessions which had stopped but should be restarted in conjunction with the use of medications. Therefore, I feel it is medically necessary to continue Abilify and I am reversing the UR decision.

Duloxetine 60 mg 60 per month for at least 12 months: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic) and Mental Illness and Stress Sections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine (Cymbalta) Page(s): 43-44.

Decision rationale: The request is considered medically necessary. The patient has severe major depressive disorder and is currently being treated with cymbalta (duloxetine) and abilify which seemed to have improved symptoms. The patient has tried a number of antidepressants without improvement. He was in psychotherapy but currently isn't which is essential for the treatment. Because the patient has been documented to be sleeping better, have improved mood symptoms, and a brighter outlook, it is beneficial to remain on current medications. Cymbalta is also used to treat neuropathic pain which the patient was diagnosed with. Therefore, I consider the request to be medically necessary.

Generic Lunesta 3 mg 60 per month for at least 12 months: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic) and Mental Illness and Stress Sections.

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

Decision rationale: The request is considered not medically necessary. The request is for retrospective prescription of Lunesta. MTUS does not have guidelines for Lunesta, therefore, ODG was used. According to ODG, Lunesta is only recommended for short-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. In general, receiving hypnotic prescriptions was associated with greater than a threefold increased hazard of death even when prescribed less than 18 pills/year. Previously recommended doses can cause impairment to driving skills, memory, and coordination as long as 11 hours after the drug is taken. Despite these long-lasting effects, patients were often unaware they were impaired. The request for a 1 month supply with a year's worth of refills exceeds the recommended three week limit. Because of these reasons, the request is considered not medically necessary.