

Case Number:	CM15-0072402		
Date Assigned:	04/22/2015	Date of Injury:	01/28/2000
Decision Date:	06/18/2015	UR Denial Date:	03/26/2015
Priority:	Standard	Application Received:	04/16/2015

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: 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 62-year-old male, who sustained an industrial injury on 1/28/00. The injured worker was diagnosed as having status post right and left shoulder surgeries, history of left ulnar nerve release and carpal tunnel release, depression and decreased testosterone due to chronic opiate use. Treatment to date has included psychotherapy sessions, right shoulder surgery for repair of rotator cuff tears, left shoulder surgeries, physical therapy, home exercise program and oral medications including Paxil, Ambien, Wellbutrin, Trazodone and Voltaren. Currently, the injured worker complains of persistent bilateral shoulder pain. Physical exam noted ongoing tenderness to the left and right shoulder. The treatment plan included continuation of current medications, continuation of current exercises and follow up appointment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Paxil 20mg #60 with 3 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressant treatment for chronic pain Page(s): 13-16.

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

Decision rationale: According to the ODG, antidepressants are recommended, although not generally as a stand-alone treatment for the treatment of depression. They are recommended for the initial treatment of presentation of major depressive disorder (MDD) that are moderate, severe, or psychotic, unless electroconvulsive therapy is part of the treatment plan. Paxil (Paroxetine) is an antidepressant drug of the selective serotonin reuptake inhibitor type. It is indicated for the treatment of major depression, obsessive-compulsive disorder, panic disorder, social anxiety, post-traumatic stress disorder, generalized anxiety disorder, and vasomotor symptoms associated with menopause. In this case, the medication is part of the patient's medical regimen for the treatment of his depression. Medical necessity for the requested medication has been established. The requested medication with 3 refills are medically necessary.

Ambien 10mg #15 with 3 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain, Zolpidem (Ambien).

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: Zolpidem (Ambien) is a prescription short-acting non-benzodiazepine hypnotic, which is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Ambien can be habit-forming, and may impair function and memory more than opioid analgesics. There is also concern that Ambien may increase pain and depression over the long-term. The treatment of insomnia should be based on the etiology, and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. In this case, the patient has depression and insomnia. He is maintained on medical therapy including Trazadone for sleep. There is no indication for both Trazadone and Ambien. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Wellbutrin 150mg #60 with 3 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressant treatment for chronic pain Page(s): 13-16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Bupropion Page(s): 27.

Decision rationale: Bupropion (Wellbutrin), a second-generation non-tricyclic antidepressant (a noradrenaline and dopamine reuptake inhibitor) has been shown to be effective in relieving neuropathic pain of different etiologies. While bupropion has shown some efficacy in neuropathic pain, there is no evidence of efficacy in patients with non-neuropathic chronic low back pain. A recent review suggested that bupropion is generally a third-line medication for diabetic neuropathy and may be considered when patients have not had a response to a tricyclic or SNRI. In this case, the medication is part of the patient's medical regimen for the treatment of his depression. Medical necessity of the requested medication has been established. The requested medication is medically necessary.

Trazodone 100mg #30 with 3 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressant treatment for chronic pain Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

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. Medical necessity of the requested medication has been established. The requested medication is medically necessary.

Voltaren gel 100mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

Decision rationale: The California MTUS Guidelines state Voltaren gel (Diclofenac) has an FDA appropriation indicated for the relief of osteoarthritis pain in joints that lend themselves to topical treatment, such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. The submitted documentation does not indicate that the injured worker had a diagnosis of osteoarthritis. Medical necessity for the requested topical gel has been not established. The requested Voltaren Gel is not medically necessary.