

Case Number:	CM13-0021964		
Date Assigned:	12/20/2013	Date of Injury:	12/01/2005
Decision Date:	01/30/2014	UR Denial Date:	08/26/2013
Priority:	Standard	Application Received:	09/09/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine, has a subspecialty in Cardiology 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 physician 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:

The patient is a 65-year-old male who reported a work related injury on 12/01/2005, specific mechanism of injury not stated. The patient subsequently presents for the following diagnoses: lumbar radiculopathy, lumbar facet arthropathy, lumbar spinal stenosis, lumbar postlaminectomy syndrome, chronic pain, and L4-5 annular tear with extrusion. The clinical note dated 12/04/2013 reports the patient presents for a pain medicine re-evaluation. The patient reports complaints of low back pain that radiates to the left lower extremity to the level of the toes. The patient's average pain level was a 5/10 with medications, and 8/10 without medications. The provider documented upon physical exam of the patient, he was in moderate distress. Range of motion of the lumbar spine revealed moderate reduction secondary to pain. Spinal vertebral tenderness was noted in the lumbar spine at L4-S1 level. Sensory and motor exams revealed no change and lumbar myofascial tenderness and spasms were noted upon palpation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cymbalta 30mg QHS #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 15-16.

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

Decision rationale: The current request is supported. The provider documents the patient utilizes Cymbalta for neuropathic pain complaints. The provider documents the patient averages a 5/10 with medication use and 8/10 without his medication regimen. Given the provider documents an increase in objective functionality and a decrease in rate of pain as a result of utilizing this medication, the request is supported. As such, the request for Cymbalta 30mg QHS #30 is medically necessary and appropriate.

Zolpidem 10mg QHS #30: Overturned

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

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: The current request is not supported. The clinical documentation submitted for review reports the patient presents with chronic pain complaints about the lumbar spine status post a work related injury sustained over 8 years ago. The clinical documentation submitted for review fails to evidence how long the patient has been utilizing Ambien for his sleep pattern complaints. California MTUS and ACOEM do not specifically address Zolpidem. Official Disability Guidelines indicate this medication is a short acting nonbenzodiazepine hypnotic which is approved for the short term, usually 2 weeks to 6 weeks, treatment of insomnia. Given that it appears the patient has utilized this medication chronic in nature and the clinical notes failed to evidence the patient's reports of the previous efficacy with use of this medication for his sleep pattern complaints, the request for Zolpidem 10mg QHS #30 is not medically necessary or appropriate.

Gabapentin 600mg 2 tablets TID #360: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18-20.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16.

Decision rationale: The current request is supported. The provider documents the patient utilizes Gabapentin for neuropathic pain complaints. The provider documents the patient averages a 5/10 with medication use and 8/10 without his medication regimen. Given the provider documents an increase in objective functionality and a decrease in rate of pain as a result of utilizing this medication, the request is supported. As such, the request for Gabapentin 600mg February tablets TID #360 is medically necessary and appropriate.