

Case Number:	CM13-0048976		
Date Assigned:	12/27/2013	Date of Injury:	03/15/2013
Decision Date:	02/24/2014	UR Denial Date:	10/08/2013
Priority:	Standard	Application Received:	11/07/2013

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 Emergency Medicine and is licensed to practice in New York and Tennessee. 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 33-year-old male who was injured on March 5, 2013 when he attempted to lift an ill coworker from the floor. The patient continued to complain of low back pain with radiation into the right lower extremity. There were no motor or sensory deficits documented on physical examination. EMG on July 29, 2013 showed moderate right S1 radiculopathy. MRI of the lumbar spine done on September 10, 2013 showed multilevel disc disease with new posterolateral herniated disc at L5-S1 posteriorly displacing the left S1 nerve root. Diagnosis was lumbar radiculopathy/radiculitis and thoracic ligamentous pain. Treatment included acupuncture, physical therapy, and medications. Requests for authorization for ambien 10 mg # 20, modified to # 15, protonix 20 mg # 60, and vicodin 5/500mg # 30 were received on September 24, 2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien;10mg #20: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Ambien is the Zolpidem, a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-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. Cognitive behavioral therapy (CBT) should be an important part of an insomnia treatment plan. A study of patients with persistent insomnia found that the addition of Zolpidem immediate release to CBT was modestly beneficial during acute (first 6 weeks) therapy, but better long-term outcomes were achieved when Zolpidem IR was discontinued and maintenance CBT continued. (Due to adverse effects, FDA now requires lower doses for Zolpidem. The dose of Zolpidem for women should be lowered from 10 mg to 5 mg for IR products (Ambien, Edluar, Zolpimist, and generic) and from 12.5 mg to 6.25 mg for ER products (Ambien CR). The ER product is still more risky than IR. In laboratory studies, 15% of women and 3% of men who took a 10-milligram dose of Ambien had potentially dangerous concentrations of the drug in their blood eight hours later. Among those who took Ambien CR, the problem was more common: 33% of women and 25% of men had blood concentrations that would raise the risk of a motor vehicle accident eight hours later. Even at the lower dose of Ambien CR now recommended by the FDA, 15% of women and 5% of men still had high levels of the drug in their system in the morning. According to SAMHSA, Zolpidem is linked to a sharp increase in ED visits, so it should be used safely for only a short period of time.

Protonix; 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: Protonix is a proton pump inhibitor (PPI). PPI's are used in the treatment of peptic ulcer disease and may be prescribed in patients who are using non-steroidal anti-inflammatory drugs and are at high risk for gastrointestinal events. Risk factors for high-risk events are age greater than 65, history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant, or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The patient in this case was using NSAID medication, did not have any of the risk factors for a gastrointestinal event.

Vicodin; 5/500mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Vicodin is the compounded medication containing Hydrocodone and acetaminophen. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain of function. It is recommended for short term use if first-line options, such as acetaminophen or NSAIDS have failed. Opioids are considered a second-line treatment for several reasons: (1) head-to-head comparisons have found that opioids produce more side effects than TCAs and gabapentin; (2) long-term safety has not been systematically studied; (3) long-term use may result in immunological and endocrine problems (including hypogonadism); (4) treatment may be associated with hyperalgesia; & (5) opioid use is associated with misuse/abuse. Opioids may be a safer choice for patients with cardiac and renal disease than antidepressants or anticonvulsants. Acetaminophen is recommended for treatment of chronic pain & acute exacerbations of chronic pain. Acetaminophen overdose is a well-known cause of acute liver failure. Hepatotoxicity from therapeutic doses is unusual. Renal insufficiency occurs in 1 to 2% of patients with overdose. The recommended dose for mild to moderate pain is 650 to 1000 mg orally every 4 hours with a maximum of 4 g/day. In this case, the patient was also prescribed two opioid medications. This increases the risk of adverse effects, including dependency. In addition, the medication was not prescribed for short term use and the criteria for opioid use were not met.