

Case Number:	CM13-0051083		
Date Assigned:	12/27/2013	Date of Injury:	04/23/1999
Decision Date:	05/06/2014	UR Denial Date:	10/03/2013
Priority:	Standard	Application Received:	11/14/2013

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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in Arizona. 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/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 injured worker is a 50-year-old man, without a significant past medical history. The worker sustained a work-related injury on 4/23/99, which resulted in chronic low back and knee pain. He has the diagnoses of displacement of lumbar disc without myelopathy, degenerative lumbar/lumbosacral intervertebral disc, post laminectomy syndrome, lumbago, thoraco/lumbosacral radiculitis, and sleep disturbances. The previous treatments have included L5/S1 microdiscectomy (11/19/09), implanted spinal cord stimulator (4/8/11), previous epidural injections, physical therapy, and oral analgesic medications. On 9/19/13, his primary provider evaluated him and medications were ordered including Oxycontin 10mg daily #30, Gralise (Gabapentin) 600mg 3 tabs nightly (90) and zolpidem 5mg nightly #30. A utilization review dated 10/3/13 denied these medications as not medically necessary. Multiple encounters by his primary provider are reviewed including 5/1/13, 9/19/13, 11/14/13, 12/15/13 and 3/5/14. On 9/19/13, the patient describes his pain as intermittent to constant, sharp, and at times tingling with radiation to his legs. The pain is rated 4/10 with medications and 9/10 without medications. The exam notes a normal neurological exam, with decreased range of motion of the lumbar spine and tenderness over the spinous processes. The gait is antalgic and the patient is unable to toe walk. The patient has requested to wean off of Oxycontin and is now taking it only daily from twice daily. The patient is taking Gralise for radicular pain and notes dry mouth and eyes. It is noted by the provider that he has failed the treatment with gabapentin and Lyrica in the past for radicular pain. On 3/5/14, the patient was noted to no longer be taking Oxycontin, is taking zolpidem every other day for insomnia, and did not tolerate Gralise, due to side effects of blurred vision and dry mouth.

IMR ISSUES, DECISIONS AND RATIONALES

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

GRALISE 600 MG: 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 SPECIFIC ANTI-EPILEPSY DRUGS Page(s): 18-19.

Decision rationale: The patient is being treated for chronic pain in the low back and knee, with Gralise (Gabapentin) and Oxycontin. The pain is described as radiating and sharp, with tingling paresthesias. The documentation supports that the medications reduce the pain by half. There is no documentation regarding functional improvement with the pain medications. The patient complains of the side effects of dry mouth and blurred vision with regards to the Gralise. The provider's progress note dated 3/5/14, states that the patient had stopped using Gralise, because these adverse side effects were not tolerable to him. Gralise (gabapentin) is an anticonvulsant medication approved by the FDA for the use of pain associated with postherpetic neuralgia and the treatment of seizures. The Chronic Pain Guidelines indicate that anticonvulsant medications are considered first line treatment for neuropathic pain. The continued use of an anticonvulsant medication depends on improved outcomes versus tolerability of side effects. Although the patient had a good response to the use of this medication with a 50% reduction in pain, the side effects were not tolerable and he has stopped using the medication. The continued use of Gralise is not medically necessary.

OXYCONTIN 10 MG: 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 OPIOIDS Page(s): 74-96.

Decision rationale: The patient is being treated for chronic pain in the low back and knee with Gralise (Gabapentin) and Oxycontin. The pain is described as radiating and sharp, with tingling paresthesias. The pain is also reported to be constant. The documentation supports that the medications reduce the pain by half. There is no documentation regarding functional improvement with the pain medications. The neurological exam is normal. The patient has expressed his desire to stop the use of opioid pain medications on multiple visits. On 5/1/13, he has decreased his dose of Oxycontin from twice daily to once daily. On 3/5/14, it is noted that the patient is using tramadol with good effect and has stopped using Oxycontin. The Chronic Pain Guidelines indicate that discontinuation of opioid therapy is appropriate when the patient requests it. The patient has asked to be tapered and taken off of Oxycontin. The continued use of Oxycontin is not medically necessary.

ZOLPIDEM 5 MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG GUIDELINES (ONLINE VERSION).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation AMBIEN (ZOLPIDEM), DRUG INFORMATION AND UPTODATE - TREATMENT OF INSOMNIA.

Decision rationale: The FDA has approved the use of Ambien for the short-term treatment of insomnia (with difficulty of sleep onset). Ambien is not approved for the long-term treatment of insomnia. When treating insomnia all patients should receive therapy for any medical condition, psychiatric illness, substance abuse or sleep disorder that may be precipitating or exacerbating the insomnia. For patients who continue to have insomnia that is severe enough to require intervention, cognitive behavioral therapy (CBT) is the initial therapy that is recommended. If a patient requires a combination of behavioral therapy and medication a short acting medication is recommended for six to eight (6-8) weeks and then tapered. If the patient is still having symptoms, they may require an evaluation in a sleep disorder center prior to the institution of long-term medications. The patient has been using Ambien for longer than eight (8) weeks. No further behavioral intervention has been recommended. The use of Ambien to treat this patient's insomnia is not medically necessary.