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| Case Number: | CM13-0052018 | | |
| Date Assigned: | 12/27/2013 | Date of Injury: | 05/24/2007 |
| Decision Date: | 08/05/2014 | UR Denial Date: | 11/04/2013 |
| Priority: | Standard | Application Received: | 11/15/2013 |

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 Anesthesiology, has a subspecialty in Acupuncture and Pain Medicine and is licensed to practice in California. 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 patient is a 61 year old male injured worker with date of injury 5/24/07 with related low back and right knee pain. Per 11/4/13 progress report, right knee pain was rated at 4/10 in intensity and was accompanied by weakness. He presented with an antalgic gait and used a cane to aid him in ambulation. It was noted that the injured worker was not tolerating medications that were provided to him well, and he would try Tylenol No. 3 1-2 a day. X-rays of the right knee dated 9/9/13 revealed no evidence of any fractures. The joint space heights were relatively normal. He has been treated with physical therapy, acupuncture, and medication management. The date of UR decision was 11/4/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETRO: AMBIEN 5MG #30 DISPENSED ON 9/9/13: 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), Treatment Index, 11th Edition, 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) Pain (Chronic), Zolpidem (ambien).

Decision rationale: The California MTUS is silent on the treatment of insomnia. With regard to Ambien, the ODG guidelines state Zolpidem is a prescription short-acting nonbenzodiazepine 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. The documentation submitted for review do not contain information regarding sleep onset, sleep maintenance, sleep quality and next-day functioning. It was not noted whether simple sleep hygiene methods were tried and failed. The request is not medically necessary.

RETRO: NORCO 2.5/325MG #60 DISPENSED ON 9/9/13: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76,91.

Decision rationale: Per California MTUS Chronic Pain Medical Treatment Guidelines p76 regarding therapeutic trial of opioids, questions to ask prior to starting therapy include (a) Are there reasonable alternatives to treatment, and have these been tried? (b) Is the patient likely to improve? (c) Is there likelihood of abuse or an adverse outcome? Per MTUS p91, Norco is indicated for moderate to moderately severe pain. The progress report dated 8/12/13 notes that the injured worker's pain was uncontrolled with Tramadol; however the severity of his pain nor the failure of first line medications is not documented.

RETRO: PRILOSEC 20MG #90 DISPENSED ON 9/9/13: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular risk Page(s): 68.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines recommend the use of proton pump inhibitors in conjunction with NSAIDs in situations in which the patient is at risk for gastrointestinal events including: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). CPMTG guidelines further specify: Recommendations: Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease:(1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g four

times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is Naproxyn plus low-dose aspirin plus a PPI. As there is no documentation of peptic ulcer, GI bleeding or perforation, or cardiovascular disease in the records available for my review, the injured worker's risk for gastrointestinal events is low, as such, medical necessity cannot be affirmed.