

Case Number:	CM13-0061877		
Date Assigned:	05/07/2014	Date of Injury:	02/24/2006
Decision Date:	07/09/2014	UR Denial Date:	11/19/2013
Priority:	Standard	Application Received:	12/05/2013

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 Physical Medicine and Rehabilitation 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 injured worker is a 56-year-old male who reported an injury on 02/20/2006. The mechanism of injury was not provided for review. The injured worker underwent laminectomy surgery that failed to provide significant relief and ultimately resulted in the development of chronic pain. The injured worker's treatment history included multiple medications, physical therapy, and injections. The injured worker was monitored for aberrant behavior with urine drug screens. The injured worker's most recent clinical evaluation was dated 04/07/2014. It was documented that the injured worker had 10/10 pain that was reduced to a 5/10 with pain medications. It was documented the injured worker's medications included tizanidine 4 mg, Nucynta 50 mg, naproxen 500 mg, gabapentin 600 mg, zolpidem 12.5 mg, and omeprazole 40 mg. Physical findings included tenderness to palpation over the right L5-S1 lumbar paraspinal musculature with limited range of motion secondary to pain and a positive right-sided straight leg raising test. The injured worker's diagnoses included chronic pain syndrome, sleep disorder, muscle pain, lumbar radiculitis, lumbar degenerative disc disease, low back pain, intervertebral disc disorder without myelopathy, and lumbar postlaminectomy syndrome. The injured worker's treatment plan included continued medication usage to assist with pain control and increase in functional capabilities, and a urine drug screen to assess for compliance. The clinical documentation submitted for review supports that the injured worker has been on the requested medications since at least 05/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

NAPROXEN 500 MG, #60 WITH THREE (3) REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MEDICATIONS FOR CHRONIC PAIN AND NSAIDs (NON-STEROIDAL ANTI-INFLAMMATORY DRUGS) Page(s): 60 AND 67.

Decision rationale: California MTUS does recommend the use of nonsteroidal anti-inflammatory drugs in the management of chronic pain. California MTUS recommends that all medications used in the management of chronic pain be supported by documentation of functional benefit and assessment of pain relief. The clinical documentation submitted for review does provide evidence that the injured worker has significant pain relief that allows for functional improvement resulting from medication usage. However, the request as it is submitted does not provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. Additionally, the request is for 3 refills. This does not allow for timely reassessment and documentation of efficacy. As such, the requested naproxen 500 mg #60 with 3 refills is not medically necessary or appropriate.

GABAPENTIN 600 MG, #90 WITH THREE (3) REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 49.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MEDICATIONS FOR CHRONIC PAIN AND ANTI-EPILEPTICS Page(s): 60 AND 16.

Decision rationale: California MTUS does recommend the use of anticonvulsants in the management of chronic pain. California MTUS recommends that all medications used in the management of chronic pain be supported by documentation of functional benefit and pain relief. The clinical documentation does indicate that the injured worker has significant pain relief resulting from medication usage that allows for an increase in function. Therefore, continued use would be indicated. However, the request is for 3 refills. This does not allow for timely reassessment and re-evaluation of the efficacy and need for ongoing medication usage. Additionally, the request does not provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested gabapentin 600 mg #90 with 3 refills is not medically necessary or appropriate.

ZANAFLEX 4 MG, #60 WITH THREE (3) REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS Page(s): 63.

Decision rationale: California MTUS does not recommend the ongoing use of muscle relaxants in the management of chronic pain. The request is for 60 pills with 3 refills. This exceeds guidelines recommendations of short durations of treatment not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. Additionally, the request as it is submitted does not provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Zanaflex 4 mg #60 with 3 refills is not medically necessary or appropriate.

AMBIEN 12.5 MG, #30 WITH THREE (3) REFILLS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines, Treatment Index, 11th Edition (Web) 2013, Formulary.

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, Insomnia Treatments.

Decision rationale: California MTUS does not address this medication. Official Disability Guidelines does support the use of pharmacological intervention for insomnia related to chronic pain. The clinical documentation submitted for review does indicate that the injured worker is diagnosed with sleep disturbances. However, an adequate assessment of the injured worker's sleep habits to support the ongoing need for pharmacological intervention is not provided. Additionally, the request is for 3 refills. Official Disability Guidelines recommend the use of Ambien be limited to short durations of treatment not to exceed 4 to 6 weeks. There are no exceptional factors noted within the documentation to support extended treatment beyond guideline recommendations. Additionally, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Ambien 12.5 mg #30 with 3 refills is not medically necessary or appropriate.