

Case Number:	CM13-0070214		
Date Assigned:	01/03/2014	Date of Injury:	11/30/2002
Decision Date:	04/25/2014	UR Denial Date:	12/06/2013
Priority:	Standard	Application Received:	12/24/2013

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 Illinois. 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 34-year-old female who reported an injury on 11/30/2002. The mechanism of injury was not stated. The patient is diagnosed as status post right knee surgery times 3, herniated nucleus pulposus of the lumbar spine, atypical-like seizures, dental caries, and history of suicidal and homicidal ideation. The patient was seen by [REDACTED] on 01/07/2014. The patient reported persistent knee pain. The patient also reported persistent lower back pain. Current medications included Ambien 10 mg, Lyrica 100 mg, methadone 5 mg, Dexilant 60 mg, Omeprazole 20 mg, Oxcarbazepine 150 mg, Sumatriptan 50 mg, and Viibryd 40 mg. Physical examination on that date revealed limited range of motion of the lumbar spine, 4/5 strength, intact sensation, tenderness across the lumbar spine area, positive straight leg raising, decreased sensation in the L5 dermatome bilaterally, and tenderness to palpation over the L4 through S1 facet capsules bilaterally. Treatment recommendations at that time included continuation of current medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

AMBIEN 10MG, #30, BETWEEN 11/12/2013 AND 2/05/2014: 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) Chronic Pain Chapter, Insomnia Treatment

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

Decision rationale: Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. As per the documentation submitted, the patient has continuously utilized this medication. However, the patient does not report persistent insomnia or sleep disturbance. There is no documentation of functional improvement as a result of the ongoing use of this medication. There is also no documentation of failure to respond to non-pharmacologic treatment, as recommended by Official Disability Guidelines. Based on the clinical information received, the request is non-certified.

METHADONE 5MG, #90, BETWEEN 11/12/2013 AND 2/05/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 61.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 61-62.

Decision rationale: California MTUS Guidelines state methadone is recommended as a second line drug for moderate to severe pain if the potential benefit outweighs the risk. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent right knee and lower back pain. Satisfactory response to treatment has not been indicated by a decrease in pain level, increase in function, or improved quality of life. Therefore, continuation of this medication cannot be determined as medically appropriate. As such, the request is non-certified.

NORTRIPTYLINE 25MG, #90, WITH THREE (3) REFILLS, BETWEEN 11/12/2013 AND 2/05/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tricyclics Page(s): 13.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

Decision rationale: California MTUS Guidelines state antidepressants are recommended as a first line option for neuropathic pain and as a possibility for non-neuropathic pain. Tricyclics are generally considered a first line agent unless they are ineffective, poorly tolerated, or contraindicated. As per the documentation submitted, there is no evidence of this patient's active utilization of this medication. The patient's previous and current medication list includes Ambien, Celebrex, Lyrica, methadone, Oxcarbazepine, Omeprazole, Sumatriptan, and Viibryd. Based on the clinical information received, the request is non-certified.

LYRICA 100MG, #180, WITH THREE (3) REFILLS, BETWEEN 11/12/2013 AND 2/05/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-20.

Decision rationale: California MTUS Guidelines state anti-epilepsy drugs are recommended for neuropathic pain. Lyrica has been documented to be effective in treatment of diabetic neuropathy and postherpetic neuralgia. As per the documentation submitted, the patient has continuously utilized Lyrica 100 mg. Despite ongoing use of this medication, the patient continues to report persistent knee and lower back pain. The patient continues to report numbness in the right lower extremity. Satisfactory response to treatment has not been indicated. Therefore, the ongoing use of this medication cannot be determined as medically appropriate. Therefore, the request is non-certified.