

Case Number:	CM14-0005105		
Date Assigned:	01/24/2014	Date of Injury:	09/02/2004
Decision Date:	06/26/2014	UR Denial Date:	12/31/2013
Priority:	Standard	Application Received:	01/13/2014

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 & 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 patient is a 59-year-old female who has filed a claim for chronic pain syndrome associated with an industrial injury date of September 02, 2004. Review of progress notes reports flare ups in the arms, which have not changed in a month. Patient reports burning sensation in the arms and legs. Pain is noted to be relatively controlled at 3-4/10, and Cymbalta seems to be helping with the symptoms. Treatment to date has included NSAIDs, opioids, muscle relaxants, Cymbalta, Gabapentin, Soma, sedatives, and trial of spinal cord stimulator. Utilization review from December 31, 2013 denied the request for Ambien CR 12.5mg #30 as there is no documentation that the patient has difficulty sleeping; Oxycodone 20mg #120 as there is no documentation that the patient has moderate to severe pain; Soma 350mg #60 as it is not recommended for chronic use; Gralise 600mg #90 as there is no documentation that the patient has postherpetic neuralgia or diabetic neuropathy; Ativan 1mg #90; and Clonidine 0.1mg #60. Reasons for denial of Ativan and Clonidine were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

AMBIEN CR 12.5MG QTY:30.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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, Ambien (zolpidem tartrate)

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and ODG was used instead. According to ODG, Ambien is approved for the short-term (usually two to six weeks) treatment of insomnia. There is also concern that they may increase pain and depression over the long-term. Patient has been on this medication since at least April 2012. There is no documentation regarding insomnia in recent progress notes. This medication is not recommended for long-term use. Therefore, the request for Ambien CR 12.5mg #30 was not medically necessary.

OXYCODONE 20MG QTY:120.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

Decision rationale: As noted on page 78-81 of the CA MTUS Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Patient has been on this medication since at least November 2012. Progress notes indicate that the patient has controlled pain at 3-4/10, for which Cymbalta has been of help. There is no documentation regarding objective functional improvement with this medication, or of periodic urine drug screens to monitor medication use. Therefore, the request for Oxycodone 20mg #120 was not medically necessary.

SOMA 350MG QTY:60.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29 and 65.

Decision rationale: Pages 29 and 65 of CA MTUS Chronic Pain Medical Treatment Guidelines state that Soma is not recommended. Carisoprodol is metabolized to meprobamate an anxiolytic that is a schedule IV controlled substance. Patient has been on this medication since at least April 2012. Also, this patient has been on benzodiazepines and opioids, for which a combination with Soma may produce serious adverse effects. Therefore, the request for Soma 350mg #60 was not medically necessary.

GRALISE 600MG QTY: 90.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-18.

Decision rationale: As stated on pages 16-18 in the CA MTUS chronic pain and medical treatment guidelines, Gabapentin is useful for treating diabetic painful neuropathy and postherpetic neuralgia, and is considered first-line for neuropathic pain. Patient has been on this medication since at least April 2012. There is note of neuropathic pain in this patient. However, there has not been improvement in symptoms with this medication. Patient is currently on Cymbalta for which pain symptoms are noted to be improving. Therefore, the request for Gralise 600mg #90 was not medically necessary.

ATIVAN 1MG QTY: 90.00: 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), Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

Decision rationale: As noted on page 24 of the CA MTUS Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. Patient has been on this medication since at least April 2012. This medication is not recommended for long-term use. There is no indication for the necessity of continued use of this medication in this patient. Therefore, the request for Ativan 1mg was not medically necessary.

CLONIDINE 0.1MG QTY: 60.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation NIH Medline Plus

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 34-35. Decision based on Non-MTUS Citation FDA (Clonidine).

Decision rationale: According to pages 34-35 of CA MTUS Chronic Pain Medical Treatment Guidelines, intrathecal Clonidine is recommended only after a short-term trial indicates pain relief in patient's refractory to opioid monotherapy or opioids with local anesthetic. The medication is FDA approved with an orphan drug intrathecal indication for cancer pain only. The

CA MTUS does not address oral administration of Clonidine. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and FDA was used instead. According to FDA, Clonidine tablets are indicated in the treatment of hypertension. In this case, it is noted that this medication is to be prescribed for profuse sweating as a sympathetic response to pain. However, this is not an indication for use of Clonidine. In addition, patient does not have hypertension. Therefore, the request for Clonidine 0.1mg #60 was not medically necessary.