

Case Number:	CM14-0108137		
Date Assigned:	08/01/2014	Date of Injury:	05/17/2010
Decision Date:	10/02/2014	UR Denial Date:	06/13/2014
Priority:	Standard	Application Received:	07/11/2014

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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 54-year-old male with a 5/17/10 date of injury. At the time (5/6/14) of request for authorization for Retrospective Review of Ambien 10 mg HS #60 DOS 5/06/14, Retrospective Review of Neurontin 600 mg #180 DOS 5/06/14, Retrospective Review of Effexor XR 75 mg #60 DOS 5/06/14, and Retrospective Review for Ultram Extended Release 150 mg #120 DOS 5/06/14, there is documentation of subjective (persistent moderate low back pain and right lower extremity pain) and objective (tenderness in the lumbar paraspinal muscles, hypersensitivity to the right lower extremity, and painful and decreased right knee range of motion) findings, current diagnoses (chronic regional pain syndrome of the right foot and chronic low back pain), and treatment to date (ongoing therapy with Ultram, Ambien, Neurontin and Effexor since at least 12/9/13 with decreased pain levels). Regarding Retrospective Review of Ambien 10 mg HS #60 DOS 5/06/14, there is no documentation of insomnia, short-term (two to six weeks) treatment of insomnia, and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of use of Ambien. Regarding Retrospective Review of Neurontin 600 mg #180 (Date of Service) 5/06/14, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of use of Neurontin. Regarding Retrospective Review of Effexor XR 75 mg #60 (Date of Service) 5/06/14, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of use of Effexor. Regarding Retrospective Review for Ultram Extended Release 150 mg #120 (Date of Service) 5/06/14, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will

be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of use of Ultram.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10 mg HS #60, Dispensed on 5/06/14: Upheld

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

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, Zolpidem Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS does not address this issue. ODG identifies Ambien (Zolpidem) as a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of chronic regional pain syndrome of the right foot and chronic low back pain. However, there is no documentation of insomnia. In addition, given documentation of ongoing treatment with Ambien since at least 12/9/13, there is no documentation of short-term (two to six weeks) treatment of insomnia. Furthermore, despite documentation of decreased pain levels with Ambien, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of use of Ambien. Therefore, based on guidelines and a review of the evidence, the request for Ambien 10 mg HS #60 Dispensed on 5/06/14 is not medically necessary and appropriate.

Neurontin 600 mg #180, Dispensed on 5/06/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy medication.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 18-19. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain, as criteria necessary to support the medical necessity of

Neurontin (gabapentin). MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of chronic regional pain syndrome of the right foot and chronic low back pain. In addition, there is documentation of neuropathic pain. However, despite documentation of ongoing treatment with Neurontin with decreased pain levels, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of use of Neurontin. Therefore, based on guidelines and a review of the evidence, the request of Neurontin 600 mg #180, Dispensed on 5/06/14 is not medically necessary.

Effexor XR 75 mg #60, Dispensed on 5/06/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Venlafaxine (Effexor) Page(s): 16; 123. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of anxiety, depression, panic disorder, social phobias, or neuropathic pain, as criteria necessary to support the medical necessity of Effexor. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of chronic regional pain syndrome of the right foot and chronic low back pain. In addition, there is documentation of neuropathic pain. However, despite documentation of ongoing treatment with Effexor with decreased pain levels, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of use of Effexor. Therefore, based on guidelines and a review of the evidence, the request of Effexor XR 75 mg #60, Dispensed on 5/06/14 is not medically necessary.

Ultram Extended Release 150 mg #120, Dispensed on 5/06/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80; 113. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; as criteria necessary to support the medical necessity of Opioids. In addition, specifically regarding Ultram, MTUS Chronic Pain Medical Treatment Guideline identifies documentation of moderate to severe pain and Ultram used as a second-line treatment (alone or in combination with first-line drugs), as criteria necessary to support the medical necessity of Ultram. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of chronic regional pain syndrome of the right foot and chronic low back pain. In addition, there is documentation of moderate chronic pain and Ultram used as a second-line treatment (in combination with first-line drugs (Neurontin)). However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, despite documentation of decreased pain levels with ongoing use of Ultram, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of use of Ultram. Therefore, based on guidelines and a review of the evidence, the request for Ultram Extended Release 150 mg #120, Dispensed on 5/06/14 is not medically necessary.