

<b>Case Number:</b>	CM14-0109598		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	09/27/2002
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	06/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/15/2014

### 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 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 presented records, indicate that this 56-year-old male was reportedly injured on September 27, 2002. The mechanism of injury was noted as a motor vehicle collision type event. The most recent progress report, dated June 30, 2014, indicated that there were ongoing complaints of neck and low back pains with bilateral lower extremity involvement. The physical examination demonstrated a 5'10, 250 pound individual who was hypertensive (160/108). The injured employee was reported to be in no acute distress. A decrease in cervical and lumbar spine range of motion was reported. There was tenderness to palpation in both the cervical and lumbar spine. Diagnostic imaging studies were not reviewed. Previous treatment included lumbar laminectomy, opioid dependence treatment, physical therapy, multiple medications and pain control conventions. A request had been made for multiple medications and was not certified in the pre-authorization process on June 23, 2014.

### 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:** 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, 12th Edition (Web), 2014, Pain, 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), Pain Chapter, Updated July 2014.

**Decision rationale:** According to the ODG guidelines, Zolpidem (Ambien) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. The guidelines specifically do not recommend them for long-term use for chronic pain. The most recent progress notes do not indicate any efficacy with this medication. As such, this request for Ambien CR 12.5mg, qty 30 is not medically necessary.

**Gabapentin 600mg, qty 90 with 11 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18-19.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-20, 49.

**Decision rationale:** This medication is indicated in the MTUS as being a first-line treatment for neuropathic pain. It was noted that there was a lumbar laminectomy and a post laminectomy syndrome has been declared. However, there was no letter diagnostic evidence presented of a verifiable neuropathic lesion. Furthermore, the current progress notes did not indicate any efficacy or utility with this medication. Lastly, a one-year subscription assumes that there is some utility with this preparation and cannot be supported. Therefore, based on the parameters noted in the MTUS and by the progress notes presented for review, request for Gabapentin 600 mg, qty 90 with 11 refills is not medically necessary.

**Mirtazapine 15mg, qty 30 with 5 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122.

**Decision rationale:** As noted in the MTUS, this medication (a.k.a. Remeron) is a tricyclic antidepressant used for the treatment of major depressive disorder. There were no progress notes indicating that such a malady exists. Additionally, there was nothing in the progress note to suggest that this medication is having any efficacy in dealing with the suggested depression. Therefore, based on the limited clinical information presented for review, request for Mirtazapine 15mg, qty 30 with 5 refills is not medically necessary.

**Norco 10/325mg, qty 240:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78.

**Decision rationale:** As outlined in the MTUS, this medication is supported for the short-term management of moderate to severe breakthrough pain. Initiative the case, the medication appears to be required indefinitely, routinely, an upper breakthrough for pain. There was no notation of the functional improvement or pain relief associated with medication. The most recent progress notes indicate urine drug screening and no other efficacy was established. Therefore, based on the limited clinical rationale presented for review, the request for Norco 10/325mg, qty 240 is not medically necessary.

**Ibuprofen 800mg, qty 90 with 5 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 70.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

**Decision rationale:** As outlined in the MTUS, this is a nonselective, non-steroidal anti-inflammatory medication, which has some indication for some type of relief in chronic low back pain. However, when noting the pain complaints, the current physical examination, and there was no objectification of any significant improvement, the continued use of this medication does not appear to be clinically indicated. Anti-inflammatory medications are the traditional 1st line treatment; however, there needs to be objective data to support that there was some proven efficacy. Seeing none, the the request for Ibuprofen 800mg, qty 90 with 5 refills is not medically necessary.

**Methocarbamol 750mg, qty 90 with 6 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-65.

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

**Decision rationale:** This medication (a.k.a. Robaxin) is noted in the literature to be related to central nervous system depressant. This individual is also being prescribed antidepressant medications. Acting as a muscle relaxant, there did not appear to be any efficacy as the physical examination demonstrated ongoing complaints. Therefore, when combining the parameters noted in the MTUS, the lack of any specific improvement in the physical examination, and there is no noted efficacy in the progress notes presented, the request for Methocarbamol 750mg, qty 90 with 6 refills is not medically necessary.

**Pantoprazole 20mg, qty 50 with 5 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

**Decision rationale:** This medication is a proton pump inhibitor useful in treatment of gastroesophageal reflux disease or considered a gastritis. The last several months of progress notes did not indicate any complaints of gastritis or gastrointestinal distress. Therefore, the clinical indication for this medication has not been objectified. As such, there was no data to support this medication for the next 6 months. The request for Pantoprazole 20mg, qty 50 with 5 refills is not medically necessary.

**Tramadol 150mg, qty 30 with 6 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82, 113.

**Decision rationale:** When noting the date of injury, the injury sustained, the surgical intervention and the multiple pain related diagnoses and by the parameters noted in the MTUS, this medication is a 2nd line treatment for chronic pain, and noting that there was no indication that the pain has improved with this medication or that there was increased functionality, there was insufficient clinical information presented to support the use of this medication over the next 7 months. There was no objective data presented indicating that this medication has had any of its intended effect. Therefore, the request for Tramadol 150 mg, qty 30 with 6 refills is not medically necessity.