

Case Number:	CM14-0017768		
Date Assigned:	04/16/2014	Date of Injury:	02/26/1998
Decision Date:	07/03/2014	UR Denial Date:	02/04/2014
Priority:	Standard	Application Received:	02/12/2014

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 Texas. 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 51 year old male who was injured on 02/26/1998. The mechanism of injury is unknown. Supplemental report dated 02/03/2014 states the patient is in much more discomfort. He is having trouble getting his medications. He has been managed for several years now on a stable analgesic regimen that is used in conjunction with spinal cord stimulation. Without the medications, he is reporting increasing discomfort. The patient's examination shows that his gait remains cane-assisted and antalgic. His lumbar spine range of motion is limited. He has referred back pain with minimal straight leg raise bilaterally at 30 to 40 degrees. There is no hamstring tightness. He has distal leg weakness bilaterally. On review of pertinent diagnostic studies, his urinary drug screen is positive for opioids. His post-op CT exam of the lumbar spine reveals no evidence of edema, there is reduced L5-S1 fusion mass. He has severe chronic pain and requires analgesics to be continued without interruption. An authorization for refill of all medication is requested. The patient has been on a stable analgesic regimen since 2008. There has been no drug-seeking behavior or request for early refill, and it is believed that he will require these medications for the foreseeable future. The treatment plan is medication management, authorization request for the following medications: Methadone 10 mg one tablet p.o. q.i.d.; Lyrica 100 mg t.i.d. for neuropathic pain; Ambien 10 mg q. h.s. for sleep disturbance; Quaalun 324 mg one p.o. q. h.s. for nocturnal cramping; and Norco 10/325 mg one tablet p.o. b.i.d. for breakthrough pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 PRESCRIPTION OF AMBIEN 10MG #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).

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

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) do not discuss the issue in dispute and therefore the Official Disability Guidelines (ODG) have been utilized. According to Official Disability Guidelines, Ambien is indicated for short-term treatment of insomnia with difficulty of sleep onset, 7-10 days. The medical records document the patient complains of low back pain with right lower extremity pain mainly into the foot. The medical records submitted do not document any subjective complaints of sleep difficulties or corroborative clinical objective findings as to establish an active diagnosis of insomnia. There is no clear indication for Ambien. Therefore, the request for Ambien is not medically necessary according to the guidelines.

1 PRESCRIPTION OF QALAAQUIN 324MG #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guideline Clearinghouse.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Restless legs syndrome (RLS) Other Medical Treatment Guideline or Medical Evidence:
<http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm218202.htm>
<http://www.rxlist.com/qualaquin-drug.htm>.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) guidelines do not discuss the issue in dispute, therefore, the Official Disability Guidelines (ODG) and other guidelines were consulted. According to the medical literature, Qualaquin is used for the treatment or prevention of nocturnal leg cramps may result in serious and life-threatening hematologic reactions, including thrombocytopenia and hemolytic uremic syndrome/thrombotic thrombocytopenic purpura (HUS/TTP). Chronic renal impairment associated with the development of TTP has been reported. The risk associated with Qualaquin use in the absence of evidence of its effectiveness in the treatment or prevention of nocturnal leg cramps outweighs any potential benefit. The medical records do not document any description of subjective symptoms nor objective findings to substantiate the need of this medication. It is very relevant that this medication is associated with significant risk and side effects. The FDA does not support the use of Quinine products for cramps, it is not approved for the prevention or treatment of night-time leg cramps. Qualaquin is approved only for treating certain types of malaria. The FDA maintains that leg cramps are not a serious health problem, while quinine can be lethal. There are other much safer alternatives available to address leg cramps. The medical necessity is not established.

1 PRESCRIPTION OF LYRICA 100MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pregabalin (Lyrica) Page(s): 99.

Decision rationale: According to the California Medical Treatment Utilization Schedule (MTUS) guidelines, Lyrica is effective in treatment of diabetic neuropathy and postherpetic neuralgia, and is considered a first-line treatment for these conditions. The medical records do not establish this patient has either of these conditions. The patient is several years postdate of injury. The medical necessity of Lyrica is not established. Therefore the request is not medically necessary.