MAXIMUS Federal Services

Case Number:	CM14-0156532		
Date Assigned:	09/26/2014	Date of Injury:	01/14/2002
Decision Date:	10/29/2014	UR Denial Date:	09/05/2014
Priority:	Standard	Application Received:	09/24/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

AXIMUS 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 and Pain Medicine, and is licensed to practice in Florida. 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 injured worker is a 50-year-old male who reported an injury on 01/14/2002 due to an unknown mechanism. The diagnoses were lumbar disc displacement and lumbar radiculopathy. The physical examination dated 08/26/2014 revealed complaints of low back pain. The pain radiated into the left buttock, lateral thigh and posterior thigh. Numbness was noted. Parathesias was noted. Weakness was noted. The injured worker had tried ice, heat application, and NSAIDs and the pain had not improved. The injured worker had a spinal cord stimulator trial. The injured worker also had facet blocks with no relief. The examination revealed paralumbar spasm was 2+ and tenderness to palpation on the right. Atrophy was present in the quadriceps. Range of motion of the spine was limited secondary to pain. Lower extremities deep tendon reflexes were absent at the knees. Sensation to light touch was decreased on the left, hypersensitive, allodynic, in the lateral thigh. Motor strength of the lower extremities measured 5/5. The medications were Norco, Lunesta, Prilosec, and baclofen. The treatment plan was to take medications as directed. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lunesta 3mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-Benzodiazepine Sedative-Hypnotics.

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

Decision rationale: The decision for Lunesta 3 mg quantity 30 is not medically necessary. The Official Disability Guidelines indicate that the use of Lunesta is for the short term treatment of insomnia (generally 2 to 6 weeks). The efficacy of this medication was not reported. The request did not indicate a frequency for the medication. The clinical documentation submitted for review did provide evidence that the injured worker had been on this medication for an extended duration of time. Therefore, the request is not medically necessary.

Prilosec 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Proton Pump Inhibitors

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, Page(s): page 67.

Decision rationale: The decision for Prilosec 20mg #30 is not medically necessary.Clinicians should determine if the patient is at risk for gastrointestinal events which include age > 65 years, a history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant; or using a high dose/multiple NSAIDs. Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. The efficacy for this medication was not reported. The injured worker did not have complaints or a diagnosis to support the use of this medication. The request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

Baclofen 10mg #30: Upheld

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

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

Decision rationale: The decision for baclofen 10 mg quantity 30 is not medically necessary. The Official Disability Guidelines indicate zolpidem (Ambien) is appropriate for the short term

treatment of insomnia (generally 2 to 6 weeks.) The request does not indicate a frequency for the medication. The efficacy of this medication was not reported. The clinical documentation submitted for review did provide evidence that the injured worker had been on this medication for an extended duration of time. Therefore, this request is not medically necessary.

Tompamax 100mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs (AEDs) Page(s): 18, 21.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Drugs, Page(s): page 16, 17.

Decision rationale: The decision for Topamax 100 mg quantity 60 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend antiepileptic medication as a first line medication for the treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30% to 50% and objective functional improvement. The request did not indicate a frequency for the medication. The efficacy of this medication was not reported. An objective decrease in pain of at least 30% to 50% and objective functional improvement were not reported. Therefore, the request is not medically necessary.