

Case Number:	CM14-0163397		
Date Assigned:	10/27/2014	Date of Injury:	02/24/1998
Decision Date:	12/08/2014	UR Denial Date:	09/18/2014
Priority:	Standard	Application Received:	10/03/2014

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 Illinois. 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 65-year-old male who reported an injury on 02/24/1998 due to an unknown mechanism. Diagnoses were lumbar radiculopathy and myofascial pain. Past treatments were not reported. Physical examination on 07/30/2014 revealed that the injured worker reported to be doing well and had full use of his walker at home. It was also reported that ADLs were good. The clinical note was handwritten and very difficult to read. It also indicated that the injured worker did not use a walker the day of the examination. Medications were Norco 10/325, Neurontin 600 mg, baclofen 10 mg, Klonopin 0.5, Ambien CR 12.5, trazodone 50 mg, Lidoderm 5% patch, and Protonix 40 mg. 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:

Retrospective request for Norco 10/325mg #120 with no refills DOS:7/30/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management Norco Page(s): 75, 78.

Decision rationale: 07/30/2014, is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend short acting opioids such as Norco for controlling chronic pain. For ongoing management, there should be documentation of the "4 A's", including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. There was no documentation of ongoing management for an opioid medication of the "4 A's". There was no objective functional improvement reported for the injured worker while taking this medication. The request submitted does not indicate a frequency for the medication. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, this request for Norco is not medically necessary.

Retrospective request for Neurontin 600mg #120 no refills DOS:7/30/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Specific Drug List, Gabapentin Page(s): 16.

Decision rationale: The decision for retrospective request for Neurontin 600 mg, quantity 120 with no refills, DOS 07/30/2014, is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that gabapentin is shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia, and has been considered as first line treatment for neuropathic pain. The efficacy of this medication was not reported. There was no improvement in the injured worker's activities of daily living. The request does not indicate a frequency for the medication. There is a lack of documentation of objective functional improvement. Continued use of this medication would not be supported. Therefore, this request for Neurontin is not medically necessary.

Retrospective request for Baclofen10mg #120 with no refills DOS:7/30/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers' Compensation, Pain Procedure Summary last updated 9/10/14

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The decision for retrospective request for baclofen 10 mg, quantity 120 with no refills, DOS 07/30/2014, is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review does not provide evidence of objective functional improvement. There is a lack of documentation of an objective assessment of the injured worker's pain level, and functional status. Also, the request does not indicate a frequency for the

medication. Continued use of this medication would not be supported. Therefore, this request for Baclofen is not medically necessary.

Retrospective request for Klonopin 0.5mg #120 with no refills DOS:7/30/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Compensation, Pain Procedure Summary last updated 9/10/14

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

Decision rationale: The decision for retrospective request for Klonopin 0.5 mg, quantity 120 with refills, DOS 07/30/2014, is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines do not recommend the use of benzodiazepines as treatment for patients with chronic pain for longer than 3 weeks due to a high risk of psychological and physiological dependency. The efficacy of this medication was not reported. There is a lack of documentation of objective functional improvement for the injured worker. There is a lack of documentation of an objective assessment of the injured worker's pain level. Also, the request does not indicate a frequency for the medication. Therefore, this request for Klonopin is not medically necessary.

Retrospective request for Ambien CR 12.5mg #30 with no refills DOS:7/30/14: 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 in Workers' Compensation, Pain Procedure Summary

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

Decision rationale: The decision for retrospective request for Ambien CR 12.5 mg, quantity 30 with no refills, DOS 07/30/2014, is not medically necessary. The Official Disability Guidelines state that zolpidem is a prescription short acting nonbenzodiazepine hypnotic, which is approved for the short term, usually 2 to 6 weeks, treatment of insomnia. Zolpidem is in the same drug class as Ambien. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short term benefit. While sleeping pills, so called minor tranquilizers, and antianxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long term use. They can be habit forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long term. Cognitive behavioral therapy (CBT) should be an important part of an insomnia treatment plan. The efficacy of this medication was not reported. There were no reports that indicated the injured worker had any improvement from insomnia. The request submitted for review does not indicate a frequency for the medication. Continued use of this medication would be not supported. Therefore, this request for Ambien CR is not medically necessary.

Retrospective request for Trazodone 50mg #90 with no refills DOS:7/30/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SSRIs Page(s): 107.

Decision rationale: The decision for retrospective request for trazodone 50 mg, quantity 90 with no refills, DOS 07/30/2014, is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that SSRIs are not recommended as a treatment for chronic pain, but SSRIs may have a role in treating secondary depression. SSRIs have not been shown to be effective for low back pain. The efficacy of this medication was not reported. There is a lack of documentation of objective functional improvement. There is a lack of documentation of an objective assessment of the injured worker's pain level. Also, the request does not indicate a frequency for the medication. Therefore, this request for Trazodone is not medically necessary.

Retrospective request for Lidoderm patch 5% #60 with no refills DOS:7/30/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Salicylates Topical Analgesics Lidoderm Page(s): 105, 111, 112.

Decision rationale: The decision for retrospective request for Lidoderm patch 5%, quantity 60 with no refills, DOS 07/30/2014, is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that topical salicylates are recommended, and topical analgesics are largely experimental in use, with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Benzocaine is similar to lidocaine and lidocaine is only recommended in a Lidoderm patch. The request for Lidoderm patch is not medically necessary.

Retrospective request for Protonix 40mg #30 with no refills DOS:7/30/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment in Workers' Compensation, Pain Procedure Summary last updated 9/10/14

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

Decision rationale: The decision for retrospective request for Protonix 40mg #30 with no refills DOS: 7/30/14: is not medically necessary. The California Medical Utilization Schedule recommends clinicians to 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 ug 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 of this medication was not reported. It was not reported that the injured worker had any type of gastrointestinal event. Also, the request does not indicate a frequency for the medication. There were no other significant factors provided to justify continued use. Therefore, this request for Protonix is not medically necessary.