MAXIMUS Federal Services

Case Number:	CM14-0027142		
Date Assigned:	06/20/2014	Date of Injury:	04/23/2002
Decision Date:	07/17/2014	UR Denial Date:	02/08/2014
Priority:	Standard	Application Received:	02/28/2014

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, has a subspecialty in Pain Medicine 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 injured worker is a 58-year-old male who reported an injury on 04/23/2002. The mechanism of injury was not provided within the medical records. The clinical note dated 04/28/2014 indicated diagnoses of postsurgical laminectomy syndrome, cervical radiculopathy, and cervical pain. The injured worker reported neck pain that radiated from the neck down the left arm. On physical exam of the cervical spine, the range of motion was restricted and the injured worker had pain that radiated on palpation. The injured worker's motor strength was intact. On sensory examination, decreased light to touch to thumb, index, and middle finger of left hand and along radial aspect of the left forearm. The injured worker reported with medication pain was more tolerable and he was able to perform activities of daily living more comfortably. The injured worker's prior treatments included diagnostic imaging, surgery, and medication management. The injured worker's medication regimen included Ambien, Colace, Lexapro, Gralise ER 300 mg, oxycodone, and Gralise ER 600 mg. The provider submitted a request for Colace, oxycodone, Lexapro, Gralise ER 300 mg, Gralise ER 600 mg, and Ambien. The request for medical necessity dated 02/05/2014 was submitted for Colace, oxycodone, Lexapro, Ambien, Gralise ER 300 mg, and Gralise ER 600 mg; however, a rationale was not provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

COLACE 100 MG #60 WITH 3 REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, Initiating Therapy Page(s): 77.

Decision rationale: The request for one prescription of Colace 100 MG #60 with three refills is not medically necessary. The California Chronic Pain Medical Treatment Guidelines states Colace should be initiated as a prophylactic treatment of constipation for opioid use. Although the injured worker is prescribed opiates, there was lack of quantified pain relief. In addition, the request did not indicate a frequency for the medication. Therefore, the request for a prescription of Colace 100 mg #60 with 3 refills is not medically necessary.

OXYCODONE 15 MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria For Use And Specific Drug List.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, Initiating Therapy Page(s): 78.

Decision rationale: The request for 15 MG #90 is not medically necessary. The California Chronic Pain Medical Treatment Guidelines recommend the use of opioids for the ongoing management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is lack of quantified pain relief with associated reduction of medication use. In addition, there is lack of evaluation of risk for aberrant drug use behaviors and side effects. Furthermore, the request does not indicate a frequency for the medication. Therefore, the request for Oxycodone 15 MG #90 is not medically necessary.

LEXAPRO 10 MG #60 WITH 3 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 402.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13.

Decision rationale: The request for LEXAPRO 10 MG #60 with three refills is not medically necessary. The California Chronic Pain Medical Treatment Guidelines recommends Lexapro as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. The documentation submitted did not indicate the injured worker had findings that would support he was at risk for depression. In addition, there was lack of significant evidence of neuropathic pain. Additionally, there was lack of quantified pain relief in the documentation provided. Furthermore, the provider did not indicate a frequency for the medication. Therefore, the request for Lexapro 10 MG #60 is not medically necessary.

GRALISE ER 300 MG #30 WITH 3 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti--Epilepsy Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs Page(s): 18.

Decision rationale: The request for Gralise ER 300 mg #30 is not medically necessary. The California Chronic Pain Medical Treatment Guidelines state Gralise (Gabapentin) has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The documentation submitted did not indicate the injured worker had findings that would support he was at risk for diabetic painful neuropathy, or postherpetic neuralgia. There was lack of evidence to support neuropathic pain. In addition, there was lack of quantified pain relief associated with reduction of medication use in the documentation. Furthermore, the request did not indicate a frequency for the medication. Therefore, the request for Gralise ER 300 MG #30 is not medically necessary.

GRALISE ER 600 MG #30 WITH 3 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti--Epilepsy Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs Page(s): 18.

Decision rationale: The request for Gralise ER 600 mg #30 is not medically necessary. The California chronic pain medical treatment guidelines Gralise (Gabapentin) has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The documentation submitted did not indicate the injured worker had findings that would support he was at risk for diabetic painful neuropathy, or postherpetic neuralgia. There was lack of evidence to support neuropathic pain. In addition, there was lack of quantified pain relief associated with reduction of medication use in the documentation. Furthermore, the request did not indicate a frequency for the medication. Therefore, the request for Gralise ER600 mg #30s is not medically necessary.

AMBIEN 100 MG #30 WITH 3 REFILLS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, Ambien.

Decision rationale: The request for Ambien 100 MG #30 is not medically necessary. The Official Disability Guidelines state that Zolpidem is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term, usually two to six 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. The guidelines also indicate while sleeping pills, so-called minor tranquilizers, and anti-anxiety 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. Ambien is approved for short term use, usually 2 to 6 weeks. The injured worker has been prescribed Ambien since at least 03/03/2014. This exceeds the Guideline recommendations of short term use. In addition, the documentation submitted did not indicate the injured worker had findings that would support he was at risk for insomnia. Furthermore, there was a lack of documentation of efficacy or functional improvement with this medication. Additionally, the provider did not indicate a frequency for this medication. Therefore, the request for 100 MG #30 is not medically necessary.