MAXIMUS Federal Services

Case Number:	CM14-0079294		
Date Assigned:	07/18/2014	Date of Injury:	04/06/2000
Decision Date:	09/23/2014	UR Denial Date:	04/29/2014
Priority:	Standard	Application Received:	05/29/2014

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 Internal Medicine 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 injured worker is a 53 year old male who sustained an injury on 04/06/00. No specific mechanism of injury was noted. The injured worker has been followed for ongoing chronic complaints of neck and low back pain with associated headaches and insomnia. Previously, the injured worker had been seen for psychotherapy regarding depression and anxiety secondary to chronic pain. The injured worker had also been followed by pain management and was provided several medications. As of 04/11/14, the injured worker had ongoing complaints of pain in the neck and low back rating 6/10 in severity with medications. Without medications, the injured worker's pain was as high as 8/10. On physical examination, there was limited range of motion noted in the lumbar spine on flexion and extension. There was noted sensitivity loss in an L4 distribution in the left lower extremity. Straight leg raise signs were reported as positive to the left at 70 degrees. The injured worker is noted to have had a prior lumbar fusion from L4 through S1 and has also received a spinal cord stimulator. Electrodiagnostic studies from November of 2013 did note a chronic right L5 radiculopathy. At this evaluation, the injured worker was continued on Celebrex 200mg 1 time daily, Cymbalta 60mg 1 daily, Pantoprazole 20mg twice daily, Gabapentin 600mg 3 times daily, and Ambien 5mg at night for insomnia. The injured worker's urine drug screen reports did note inconsistent findings for Morphine which was not a listed medication. The injured worker also had negative findings for Ambien. Follow up on 05/23/14 noted no change in the injured worker's symptoms; however, pain scores were elevated to 10/10 pain without medications reducing to 8/10 with medications. It is noted the injured worker underwent an intrathecal pump refill at this visit with Morphine Sulfate. The daily infusion rate was set at 3.6mg per day. The requested Cymbalta 60mg, quantity 45, Pantoprazole 20mg, quantity 90, Gabapentin 600mg, quantity 150, and Ambien 5mg, quantity 45 were all denied by utilization review on 04/29/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cymbalta 60mg #45 QTY: 45: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 15-16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTI-DEPRESSANTS Page(s): 13-16.

Decision rationale: In regards to the request for Cymbalta 60mg, quantity 45, this reviewer would have recommended this request as medically necessary based on review of the clinical documentation submitted as well as current evidence based guidelines. Cymbalta is a 1st line recommended antidepressant that can be utilized for the treatment of depression and chronic pain as well as neuropathic pain. In this case, the injured worker has been followed for continuing complaints of chronic low back pain stemming from a previous lumbar fusion. The injured worker does have a spinal cord stimulator placed; however, Cymbalta is an effective medication to address chronic pain as well as neuropathic pain. In this case, there is sufficient evidence to warrant the continued use of this medication at the requested quantity. Therefore, this reviewer would have recommended this request as medically necessary.

Pantoprazole 20mg #90 QTY: 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS(non-steroidal anti-inflammatory drugs Page(s): 67,68,70.

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, proton pump inhibitors.

Decision rationale: In regards to the use of Pantoprazole 20mg quantity 90, this reivewer would not have recommended this medication as medically necessary based on the clincial documentatin provdied for review and current evidence based guideline recommendations. The clinical records provided for review did not discuss any side effects from oral medication usage including gastritis or acid reflux. There was no other documentation provided to support a diagnosis of gastroesophageal reflux disease. Given the lack of any clinical indication for the use of a proton pump inhibitor this reviewer would not have recommended this request as medically necessary.

Gabapentin 600mg #150 QTY: 150: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTI-CONVULSANTS Page(s): 16-22.

Decision rationale: In regards to the request for Gabapentin 600mg, quantity 150, this reviewer would have recommended this request as medically appropriate. It is noted that this medication was modified for a quantity of 50 in the prior utilization report; however, this reviewer would disagree with this determination. The injured worker does clearly demonstrate objective evidence consistent with chronic radiculopathy secondary to lumbar fusion procedures. In this reviewer's opinion, the injured worker did reasonably require the continuing use of Gabapentin which is a recommended 1st line medication for the treatment of neuropathic pain. The clinical documentation submitted for review would support the continuing use of Gabapentin given the injured worker's radicular symptoms. Therefore, this request is medically necessary.

Ambien 5mg #45 QTY: 45: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG(The Official Disability Guidelines) pain (updated 04/10/14) Zolpidem (Ambien).

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, Zolpidem.

Decision rationale: In regards to the use of Ambien 5mg quantity 45, this reivewer would not have recommended this medication as medically necessary based on the clincial documentation provided for review and current evidence based guideline recommendations. The use of Ambien to address insomnia is recommended for a short term duration no more than 6 weeks per current evidence based guidelines. The clinical documentation submitted for review does not provide any indications that the use of Ambien has been effective in improving the claimant's overall functional condition. Furthermore, the provided urine drug screen results show inconsistent negative findings for this medication. As such, this reviewer would not recommend this medication as medically necessary.