MAXIMUS Federal Services

Case Number:	CM14-0080256		
Date Assigned:	07/18/2014	Date of Injury:	07/20/1994
Decision Date:	09/12/2014	UR Denial Date:	04/30/2014
Priority:	Standard	Application Received:	05/30/2014

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 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 61-year-old female who reported an injury on 07/20/1994. The mechanism of injury was a fall. The diagnosis included C4-6 un-instrumented anterior cervical fusion, cervical spondylosis, multilevel lumbar spondylosis. Previous treatments included medication, epidural steroid injections, physical therapy, chiropractic sessions, and acupuncture. Within the clinical note dated 06/27/2014, it was reported the injured worker complained of neck and bilateral upper extremity pain, mid back pain, and lower back pain radiating into both lower extremities down the feet. Upon the physical examination, the provider noted the range of motion of the cervical spine was flexion at 45 degrees. Upon examination of the thoracolumbar spine, the provider noted that the noted was flexion at 70 degrees. The provider requested for Xanax, Norco, zolpidem, promethazine, and gabapentin. However, the rationale was not provided for clinical review. The Request for Authorization was submitted and dated on 05/19/2014 and 06/30/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Xanax 0.5 mg #30 with one refill: Upheld

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

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

Decision rationale: The request for Xanax 0.5 mg #30 with 1 refill is not medically necessary. The California MTUS Guidelines do not recommend Xanax for long term use due to its long term efficacy being unproven and the risk of dependence. The guidelines also recommend the limited use of Xanax to 4 weeks. The injured worker had been utilizing the medication since at least 01/2014 which exceeds the guideline's recommendation of short term use of 4 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

Norco 10/325 mg #30 with two refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: The request for Norco 10/325 mg #30 with 2 refills is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, and poor pain control. The provider did not document an adequate and complete pain assessment within the documentation. There is lack of documentation indicating the medication had been providing objective functional benefit and improvement. Additionally, the use of the urine drug screen was not provided for clinical review. Therefore, the request is not medically necessary.

Zolpidem tartrate 12.5 mg #30 wth three refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines and Mosby's Drug Consultation.

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

Decision rationale: The request for zolpidem tartrate 12.5 mg #30 for 3 refills is not medically necessary. The Official Disability Guidelines note zolpidem is a prescription short acting non-benzodiazepine hypnotic, which was approved for short term use, usually 2 to 6 weeks treatment of insomnia. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. There is lack of documentation indicating the injured worker is treated for or diagnosed with insomnia. Additionally, the request submitted failed to provide the frequency of the medication. The injured worker has been utilizing the

medication since at least 01/2014 which exceeds guideline's recommendation of short term use of 2 to 6 weeks. Therefore, the request is not medically necessary.

Promethazine 12.5 mg #30 with three refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Consult.

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

Decision rationale: The request for promethazine 12.5 mg #30 with 3 refills is not medically necessary. The Official Disability Guidelines note promethazine is not recommended for nausea and vomiting secondary to opioid use. Furthermore, the presence of longstanding symptoms of nausea and/or vomiting do warrant additional workup to evaluate the etiology of these symptoms. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

Gabapentin 600 mg #90 with three refills: 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 Gabapentin Page(s): 49.

Decision rationale: The request for gabapentin 600 mg #90 with 3 refills is not medically necessary. The California MTUS Guidelines note gabapentin has been shown to be effective for diabetic pain neuropathy and post-herpetic neuralgia and has been considered as a first line treatment for neuropathic pain. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. There is lack of documentation indicating the injured worker was treated or diagnosed with diabetic pain neuropathy or post-herpetic neuralgia. Therefore, the request is not medically necessary.