

Case Number:	CM14-0087146		
Date Assigned:	08/01/2014	Date of Injury:	05/31/2006
Decision Date:	09/29/2014	UR Denial Date:	05/27/2014
Priority:	Standard	Application Received:	06/10/2014

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 Nevada. 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 records, presented for review, indicate that this 62-year-old male was reportedly injured on May 31, 2006. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated May 19, 2014, indicated that there were ongoing complaints of low back pain. The past medical history was significant for diabetes, hypertension and hypercholesterolemia as well as a pancreatitis. The physical examination demonstrated a well-developed, well-nourished individual who is in no acute distress. The injured employee has an antalgic gait, used a walking stick, and a decrease in lower extremity strength (1+) was noted. An absent deep tendon reflexes at the Achilles was also reported. Diagnostic imaging studies were not reported. Previous treatment included lumbar surgery, hernia repair, multiple medications and pain management interventions. A request had been made for multiple medications and was not certified in the pre-authorization process on May 27, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10mg #30 per 05/19/2014: 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 Index, Integrated Treatment,/Disability Duration Guidelines, Pain (chronic), Zolpidem.

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, updated August 2014 (electronically cited).

Decision rationale: As outlined in the ODG (MTUS and ACOEM guidelines do not address), this medication is a short acting, non-benzodiazepine hypnotic, indicated for the short-term treatment (usually two to six weeks) to address insomnia complaints. The progress notes, presented for review, do not indicate any increase in sleep hygiene or otherwise establish the efficacy of this medication. It is noted that sleep hygiene is critical to a chronic pain situation, but there needs to be objectification of a specific utility with the medication before continuing. Seeing none and by the parameters noted in the MTUS, this is not medically necessary.

Tizanidine 4mg #30 per 05/19/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs Page(s): 66.

Decision rationale: As outlined in the MTUS, this is a centrally acting alpha-2 antigenic agonist indicated for management of spastic pain. This is unlabeled for use in low back pain. Furthermore, when noting the date of injury, the injury sustained, the current physical examination reported, there is no clinical indication presented that this medication is demonstrating any efficacy whatsoever. As such, when noting the clinical findings combined with the parameters noted in the MTUS, the request is not medically necessary.

Refill Tizanidine 4mg #30 per 05/19/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs Page(s): 66.

Decision rationale: As outlined in the MTUS, this is a centrally acting alpha-2 antigenic agonist indicated for management of spastic pain. This is unlabeled for use in low back pain. Furthermore, when noting the date of injury, the injury sustained, the current physical examination reported, there is no clinical indication presented that this medication is demonstrating any efficacy whatsoever. As such, when noting the clinical findings combined with the parameters noted in the MTUS, the request is not medically necessary.

Refill Pamelor 25mg #30 per 05/19/2014: 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 Page(s): 43, 105.

Decision rationale: There is qualitative evidence of evaluating anti-depressants for the treatment of chronic pain. The inhibition of norepinephrine reuptake appears to be the key mechanism of analgesia. The prototypical medications to produce these effects are the TCAs (e.g., amitriptyline, imipramine, and nortriptyline [aka Pamelor]). The newer dual reuptake inhibiting medications are as effective as the older norepinephrine reuptake inhibitors. As there is no evidence of superiority of the dual reuptake inhibitors and cost considerations are considerable, it is recommended that the older medications be tried first. However, the progress notes did not establish that there has been any efficacy with this medication. The pain complaints remained the same, and the lack of improved functionality was noted, and there simply was no evidence to support the medical necessity. Therefore the request is not medically necessary.

Norco 10/325mg #240 per 05/19/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78, 88, 91.

Decision rationale: As outlined in the MTUS, this is a short acting opioid indicated for the medical treatment for severe breakthrough pain. The lowest possible dose should be used to demonstrate decreased pain and increased functionality. The progress notes for review do not indicate that there has been any increased functionality or decrease in pain with use of this medication. As such, the clinical indication for the continued use of this medication has not been established. No efficacy whatsoever is noted and therefore the request is not medically necessary.

Dilaudid 4mg #30 per 05/19/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydromorphone Page(s): 93.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-75, 78, 93.

Decision rationale: The MTUS supports short-acting opiates for the short-term management of severe breakthrough pain. However, the records indicate that there is a chronic or indefinite indication for the use of this medication. There needs to be objective documentation of improved functionality or significant pain relief. Based on the progress notes presented for review, neither is present. As such, the medical necessity for the ongoing use of this medication has not been established and therefore the request is not medically necessary.

Dilaudid 4mg #30 per 05/19/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydromorphone Page(s): 93.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-75, 78 & 93.

Decision rationale: The MTUS supports short-acting opiates for the short-term management of severe breakthrough pain. However, the records indicate that there is a chronic or indefinite indication for the use of this medication. There needs to be objective documentation of improved functionality or significant pain relief. Based on the progress notes presented for review, neither is present. As such, the medical necessity for the ongoing use of this medication has not established and therefore the request is not medically necessary.

Ambien 10mg #30 per 05/19/2014: 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 Index, Integrated Treatment,/Disability Duration Guidelines, Pain (chronic), Zolpidem.

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, updated August 2014 (electronically sited).

Decision rationale: As outlined in the ODG (MTUS and ACOEM guidelines do not address), this medication is a short acting, non-benzodiazepine hypnotic, indicated for the short-term treatment (usually two to six weeks) to address insomnia complaints. The progress notes presented for review do not indicate any increase in sleep hygiene or otherwise establish the efficacy of this medication. It is noted that sleep hygiene is critical to a chronic pain situation, but there needs to be objectification of a specific utility with the medication before continuing. Seeing none and by the parameters noted in the MTUS, this is not medically necessary.