

Case Number:	CM14-0089806		
Date Assigned:	09/10/2014	Date of Injury:	11/07/2003
Decision Date:	10/03/2014	UR Denial Date:	05/30/2014
Priority:	Standard	Application Received:	06/13/2014

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, has a subspecialty in Interventional Spine 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 patient is a 47-year-old male with a date of injury of 11/07/2003. The listed diagnosis per [REDACTED] is right lower extremity pain. According to progress report 05/21/2014, the patient presents with low back and right lower extremity pain. The patient is reporting a "popping" sensation when moving in a flexion and extension manner with associated severe pain in his lower thoracic and upper lumbar region. He is currently taking Neurontin, Amrix 30 mg, Norco 10/325 mg. Physical examination revealed decreased sensation to light touch and pinprick at the dorsum of the 5th toe on the right side. The patient has decreased sensation to light touch and pinprick along both the medial and lateral aspect of the right plantar surface of his heels. Reflexes were brisk at 3+ in the upper and lower extremities. Treater is requesting Neurontin 800 mg #30 for his neuropathic pain and Ambien 10 mg #30 for his sleep difficulties. Utilization review denied the request on 05/30/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurontin 800mg with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin, Gabarone, generic available) Page(s): 18,19.

Decision rationale: This patient presents with low back pain that radiates into the bilateral lower extremities. The treater is requesting a refill of Neurontin 800 mg with 1 refill. The MTUS Guidelines page 18 and 19 has the following regarding gabapentin, "Gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and post therapeutic neuralgia and has been considered a first-line treatment for neuropathic pain." Review of the medical file indicates the patient has been prescribed this medication since 12/17/2013. In this case, the treater has provided this medication on a monthly basis but it appears the patient continues with significant pain. Given the patient has neuropathic pain, this medication may be indicated. However, the treater does not discuss pain relief or functional changes with taking this medication. MTUS page 60 requires documentation of pain assessment and functional changes when medications are used for chronic pain. The request is not medically necessary.

Ambien 10mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ambien for insomnia Zolpidem.

Decision rationale: This patient presents with back pain that radiates into the bilateral lower extremities. Treater states the patient is having difficulties with sleep and has provided a prescription for Ambien 10 mg #30. The MTUS and ACOEM Guidelines do not address Ambien. However, ODG Guidelines states that zolpidem (Ambien) is indicated for short-term treatment of insomnia with difficulty of sleep onset 7 to 10 days. ODG Guidelines does not recommend long-term use of this medication. The treater has prescribed #30. The request is not medically necessary.