

Case Number:	CM14-0095222		
Date Assigned:	09/15/2014	Date of Injury:	10/10/2006
Decision Date:	11/10/2014	UR Denial Date:	06/02/2014
Priority:	Standard	Application Received:	06/23/2014

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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 57-year-old female with a 10/10/08 date of injury, and anterior/posterior decompression and fusion with instrumentation at L4-L5 on 5/31/12. At the time (6/2/14) of Decision for Neurontin 300 mg #60, Norco 10/325 mg #60, Xanax 0.25 mg #15, and Ambien 10mg #15 there is documentation of subjective (chronic radiating low back pain) and objective (tenderness to palpation over the lumbar paraspinal muscles, positive straight leg raise, and decreased sensation in the bilateral S1 dermatomal pattern with pinwheel) findings, current diagnoses (status post L4-L5 anterior/posterior decompression and fusion with instrumentation, chronic low back pain, and lumbar radiculopathy), and treatment to date (medications (including ongoing treatment with Neurontin, Norco, Xanax, and Ambien since at least 3/19/14)).

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurontin 300mg, #60:

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDs) Page(s): 16-18, 24, 74-82.

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain, as criteria necessary to support the medical necessity of Neurontin (gabapentin). MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of status post L4-L5 anterior/posterior decompression and fusion with instrumentation, chronic low back pain, and lumbar radiculopathy. In addition, there is documentation of neuropathic pain. However, given documentation of ongoing treatment with Neurontin, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Neurontin use to date. Therefore, based on guidelines and a review of the evidence, the request for Neurontin 300 mg #60 is not medically necessary.

Norco 10/325mg, #60: Overturned

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): 74-80.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of status post L4-L5 anterior/posterior decompression and fusion with instrumentation, chronic low back pain, and lumbar radiculopathy. In addition, given documentations of CURES appropriate medications, there is documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Furthermore, given documentation of ongoing treatment with Norco and a decrease in pain level, ability to perform greater activities such as walking and standing longer periods of time as a result of Norco use, there is documentation of functional benefit and improvement as an increase in activity tolerance as result of Norco use to date. Therefore, based on guidelines and a review of the evidence, the request for Norco 10/325mg, #60 is medically necessary.

Xanax 0.25mg, #15: 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: MTUS Chronic Pain Medical Treatment Guidelines identifies that benzodiazepines are not recommended for long-term and that most guidelines limit use to 4 weeks. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of status post L4-L5 anterior/posterior decompression and fusion with instrumentation, chronic low back pain, and lumbar radiculopathy. However, given documentation of records reflecting prescriptions for Xanax since at least 3/19/14, there is no documentation of intention to treat over a short course (up to 4 weeks). In addition, given documentation of ongoing treatment with Xanax, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Xanax use to date. Therefore, based on guidelines and a review of the evidence, the request for Xanax 0.25mg, #15 is not medically necessary.

Ambien 10mg, #15: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Insomnia Treatment Chapter

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

Decision rationale: MTUS does not address this issue. ODG identifies Ambien (zolpidem) as a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of status post L4-L5 anterior/posterior decompression and fusion with instrumentation, chronic low back pain, and lumbar radiculopathy. However, there is no documentation of Insomnia. In addition, given documentation of records reflecting prescription for Ambien since at least 3/19/14, there is no documentation of short-term (less than two to six weeks) treatment. Furthermore, given documentation of ongoing treatment with Ambien, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Ambien use to date. Therefore, based on based on guidelines and a review of the evidence, the Ambien 10mg, #15 is not medically necessary.