

Case Number:	CM15-0105950		
Date Assigned:	06/10/2015	Date of Injury:	04/13/2014
Decision Date:	07/15/2015	UR Denial Date:	05/15/2015
Priority:	Standard	Application Received:	06/02/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative Medicine

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 sustained an industrial injury on 04/13/2014. Diagnoses include 6mm protrusion L5-S1 with right neural encroachment, lumbar radiculopathy, and lumbar sprain/strain. Treatment to date has included diagnostic studies, medications, epidural steroid injections, activity modification, physical therapy, Transcutaneous Electrical Nerve Stimulation unit, and lumbar brace and home exercise. A physician progress note dated 04/08/2015 documents the injured worker complains of low back pain with left greater than right lower extremity symptoms. She rates her pain as 6 out of 10 on the pain scale. She is status post epidural lumbar injection in January 2015 and it facilitates diminution in radicular pain and improves tolerance to standing and walking. Her medications facilitate maintenance of activities of daily living, such as light household duties, shopping for groceries, grooming and cooking. There is tenderness to the lumbar spine. Lumbar range of motion is normal. She has a positive straight leg raise for pain to foot at 35 degrees. The treatment plan includes proceeding with the second epidural injection to the lumbar spine. She is to continue with the use of the Transcutaneous Electrical Nerve Stimulation unit, and lumbar brace. Transcutaneous Electrical Nerve Stimulation unit supplies are requested. She has been consuming up to 9 hydrocodone per day and she is to consume no more than 5 hydrocodone per day. Duloxetine 30mg, twice a day #60 was dispensed. Hydrocodone 10/325mg #60, twice a day for severe and breakthrough pain, Naproxen 550mg one three times a day, Pantoprazole 20mg, three times a day # 90, and Cyclobenzaprine 7.5mg, one three times a day as needed for spasm, # 90 were dispensed. A pain management consultation was requested. Treatment requested is for Ambien 10 mg Qty 30, Gabapentin 6% in base, Qty 300 grams, and Hydrocodone 10/325 mg Qty 60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 10/325 mg Qty 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 44, 47, 75-79, 120 of 127.

Decision rationale: Regarding the request for hydrocodone/acetaminophen, California Pain Medical Treatment Guidelines state that Hydrocodone is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that this medication is improving the patient's function (in terms of specific examples of objective functional improvement), no documentation regarding side effects. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested hydrocodone/acetaminophen is not medically necessary.

Ambien 10 mg Qty 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: Pain chapter - 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) Chronic Pain, Sleep Medication, Insomnia treatment.

Decision rationale: Regarding the request for Ambien, California MTUS guidelines are silent regarding the use of sedative hypnotic agents. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there are no subjective complaints of insomnia, no discussion regarding how frequently the insomnia complaints occur or how long they have been occurring, no statement indicating what behavioral treatments have been attempted for the condition of insomnia, and no statement indicating how the patient has responded to Ambien treatment. Finally, there is no indication that Ambien is

being used for short term use as recommended by guidelines. In the absence of such documentation, the currently requested Ambien is not medically necessary.

Gabapentin 6% in base, Qty 300 grams: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 113 of 127.

Decision rationale: Regarding topical gabapentin, Chronic Pain Medical Treatment Guidelines state that topical anti-epileptic medications are not recommended. They go on to state that there is no peer-reviewed literature to support their use. Therefore, in the absence of guideline support for the use of topical gabapentin, the currently requested gabapentin is not medically necessary.