MAXIMUS Federal Services

Case Number:	CM15-0188128		
Date Assigned:	09/30/2015	Date of Injury:	01/02/2005
Decision Date:	11/09/2015	UR Denial Date:	09/15/2015
Priority:	Standard	Application Received:	09/24/2015

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
Certification(s)/Specialty: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 60 year old female, who sustained an industrial injury on 01-02-2005. The injured worker was diagnosed as having displacement of lumbar intervertebral disc without myelopathy, unspecified internal derangement of knee, postlaminectomy syndrome-cervical region and chronic pain syndrome. On medical records dated 09-04-2015 and 07-08-2015, the subjective complaints were noted as lower back and that radiates to right leg and neck pain that radiates to left shoulder. Pain was noted as 7-8 out of 10. Objective findings were noted as cervical spine revealed limitation range of motion with forward flexion extension. Cervical rotation and side bending was noted. Tenderness to palpation over the left sided cervical paraspinal muscles, superior trapezius, levator scapula and rhomboid muscles. Lumbar spine revealed limitation of lumbar range of motion. Tenderness to palpation over the bilateral lumbar paraspinal muscles consistent with lumbar paraspinals spasms. Positive straight leg raise on the right and diffuse decreased sensory function over L4, L5 and S1 distribution was noted. Deep tendon reflexes were noted as normal. No insomnia or sleep disturbance was noted on 09-04-2015. Treatments to date included lumbar epidural steroid injection which was noted to have controlled right sides sciatica in the past. Current medications were listed as Hydrocodone, Gabapentin, Ambien, and Cyclobenzaprine. The Utilization Review (UR) was dated 09-15-2015. A Request for Authorization was dated 09-10-2015. The UR submitted for this medical review indicated that the request for Gabapentin 600mg #90, Ambien 10mg #15 and one lumbar epidural steroid injection L4-L5, L5-S1 levels was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 600mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: Although Neurontin (Gabapentin) has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain; however, submitted reports have not adequately demonstrated the specific symptom relief or functional benefit from treatment already rendered for this chronic injury. Medical reports have not demonstrated specific change, progression of neurological deficits or neuropathic pain with functional improvement from treatment of this chronic 2005 injury in terms of increased ADLs and work status, decreased pharmacological dosing and medical utilization for this chronic injury. Previous treatment with Neurontin has not resulted in any functional benefit and medical necessity has not been established. The Gabapentin 600mg #90 is not medically necessary and appropriate.

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 (Acute and Chronic): 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) Pain (Chronic): Zolpidem (Ambien®), pages 877-878.

Decision rationale: MTUS Guidelines is silent; however, per the ODG, this non-benzodiazepines CNS depressant should not be used for prolonged periods of time and is the treatment of choice in very few conditions. The tolerance to hypnotic effects develops rapidly with anxiolytic effects occurring within months; limiting its use to 4 weeks as long-term use may actually increase anxiety. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. Submitted reports have not identified any clinical findings or specific sleep issues such as number of hours of sleep, difficulty getting to sleep or staying asleep or how the use of this sedative/hypnotic has provided any functional improvement if any from treatment rendered. The reports have not demonstrated any clinical findings or confirmed diagnoses of sleep disorders to support its use for this chronic injury. There is no failed trial of behavioral interventions or conservative sleep hygiene approach towards functional restoration. The Ambien 10mg #15 is not medically necessary and appropriate.

One lumbar epidural steroid injection L4-5, L5-S1 levels: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines recommend ESI as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy); however, radiculopathy must be documented on physical examination and corroborated by imaging studies and/or Electrodiagnostic testing, not provided here. Submitted reports have not demonstrated any correlating neurological deficits or remarkable diagnostics to support the epidural injections. In addition, to repeat a LESI in the therapeutic phase, repeat blocks should be based on continued objective documented decreasing pain and increasing functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks. Criteria for repeating the epidurals have not been met or established as the patient continues to treat for chronic pain without functional benefit from previous injections in terms of decreased pharmacological formulation, increased ADLs and decreased medical utilization. There is also no documented failed conservative trial of physical therapy, medications, activity modification, or other treatment modalities to support for the epidural injection. Lumbar epidural injections may be an option for delaying surgical intervention; however, there is no surgery planned or identified pathological lesion noted. The One lumbar epidural steroid injection L4-5, L5-S1 levels is not medically necessary and appropriate.