

<b>Case Number:</b>	CM15-0031675		
<b>Date Assigned:</b>	02/25/2015	<b>Date of Injury:</b>	01/13/2009
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	01/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/19/2015

### 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, Indiana, New York  
 Certification(s)/Specialty: Internal 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 64 year old female, who sustained a work/ industrial injury on 1/13/09. While walking to her car in a parking lot of school on way to her classroom, she was hit on the right side. She has reported symptoms of radiculopathy and neuropathic pain. Prior medical history includes diverticulosis. The diagnoses have included post laminectomy syndrome, left shoulder internal derangement, depression, and anxiety. Treatments to date included diagnostics, physical therapy, medication, left total knee replacement (8/5/13), sacroiliac fusion (6/25/12) and multiple surgeries. Diagnostics included a Magnetic Resonance Imaging (MRI) noted full thickness tear of supraspinatus with 1 cm retraction, moderate fluid within the subacromial subdeltoid bursa. MR I of the lumbar spine reported s/p posterior fusion, no evidence of canal stenosis, mild right neural foraminal narrowing, fat signal intensity is seen surrounding the exiting right L4 nerve root, disk is desiccated at L5-S1 level with disc bulge causing no significant narrowing or canal stenosis, bilateral hypertrophic facet degenerative changes are seen, right paracentral disk bulge at L3-4 level, and degenerative changes at L2-3. Medications included OxyContin, Peri-colace. The physician's report from 12/30/14 indicated the spinal exam showing pain with extension and rotation, no focal deficits, 1+ pulses, 5/5 motor examination in the lower extremities, good range of motion of the hips, knees, and ankles. Paraspinal spasm is present there. On 1/26/15, Utilization Review non-certified a Peri-colace #60; Topamax 50mg #30; Modified OxyContin 10mg #60 to OxyContin 10 mg #30, noting the California Medical treatment Utilization Schedule (MTUS) Guidelines. On 1/26/15, Utilization Review non-certified a Ambien 10mg #30; Ranitidine 150mg #30, noting the Official Disability Guidelines

(ODG) and Quaalun 325mg #30, non Medical treatment Utilization Schedule (MTUS) :  
<http://www.ncbi.nlm.nih.gov/pubmed/18454580>.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Ranitidine 150mg #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 (ODG) Integrated Treatment/Disability Duration Guidelines, Pain (Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation  
<http://www.nlm.nih.gov/medlineplus/druginfo/meds/a601106.html>.

**Decision rationale:** Pursuant to Medline plus, ranitidine 150 mg #30 is not medically necessary. Ranitidine is an H2 receptor blocker used to treat ulcers, gastroesophageal reflux disease, dyspepsia, and the condition where the stomach produces too much acid called Zollinger Ellison syndrome. For additional details see the attached link. In this case, the injured worker's working diagnoses are left shoulder internal derangement; status post left knee replacement; urinary voiding difficulty; constipation; depression and anxiety; left foot sprain secondary to unstable gait; status post right shoulder rotator cuff tear 2011. The documentation shows the injured worker is on Dexilant in addition to Ranitidine. There is no clear-cut rationale for the dual use of proton pump inhibitor in addition to an H2 receptor blocker. Consequently, absent clinical documentation with a clear clinical indication and or rationale for the dual use of Dexilant and Ranitidine, Ranitidine 150 mg #30 is not medically necessary.

#### **Peri-colace #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.empr.com/peri-colace/drug/1418/>.

**Decision rationale:** Pursuant to Medline plus, Pericolace is not medically necessary. Pericolace is a medication used to treat constipation. For additional details see the attached link. . In this case, the injured worker's working diagnoses are left shoulder internal derangement; status post left knee replacement; urinary voiding difficulty; constipation; depression and anxiety; left foot sprain secondary to unstable gait; status post right shoulder rotator cuff tear 2011. There are no subjective complaints documented in the medical record. PeriColace started November 26, 2013. There is no documentation medical record indicating objective functional improvement. The treating physician prescribed Amitiza (a second line drugs for constipation) in addition to the pericolace. Consequently, absent clinical documentation with objective functional improvement with the ongoing use of Pericolace in addition to Amitiza, Pericolace 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 (ODG) Chronic Pain, 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 section, Ambien (Zolpedem).

**Decision rationale:** Pursuant to the Official Disability Guidelines, Ambien 10 mg #30 is not medically necessary. Ambien (zolpidem) is a short acting non-benzodiazepine hypnotic recommended for short-term (7 to 10 days) treatment of insomnia. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely recommend them for long-term use. They can be habit forming and may impair function and memory more than opiates. The dose for Ambien and women should be lowered from 10 mg to 5 mg for immediate release products and from 12.5 mg to 6.25 mg for extended-release products (Ambien CR). In this case, the injured worker's working diagnoses are left shoulder internal derangement; status post left knee replacement; urinary voiding difficulty; constipation; depression and anxiety; left foot sprain secondary to unstable gait; status post right shoulder rotator cuff tear 2011. The treating physician prescribed Ambien as far back as November 26, 2013. Ambien is indicated for short-term (7 to 10 days) treatment of insomnia. The treating physician has exceeded the recommended guidelines for short-term use with treatment in excess of one year. Additionally, there is no evidence of objective functional improvement with Ambien. Consequently, absent compelling clinical documentation with objective functional improvement in contravention of the recommended guidelines for short-term use, Ambien 10 mg #30 is not medically necessary.

**Topamax 50mg #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-22. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain.

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

**Decision rationale:** Pursuant to the Official Disability Guidelines, Topamax 50 mg #30 is not medically necessary. Topamax is it anti-epilepsy drug (AED) for pain. AED's are recommended for neuropathic pain. Topamax has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of central ideology. It is still considered for used for neuropathic pain when other anticonvulsants have failed (second line treatment). In this case, the injured worker's working diagnoses are left shoulder internal derangement; status post left knee replacement; urinary voiding difficulty; constipation; depression and anxiety; left foot sprain

secondary to unstable gait; status post right shoulder rotator cuff tear 2011. The treating physician indicated Topamax was prescribed for migraine headache prophylaxis. Topamax is recommended for neuropathic pain. The documentation indicates Topamax was first prescribed March 14, 2014 for migraine prophylaxis. The treating physician has not documented neuropathic evidence of objective functional improvement with ongoing Topamax treatment. The diagnoses did not list migraine headaches as an employment related injury. Consequently, absent clinical documentation with objective functional improvement and an appropriate clinical indication (in the absence of work-related migraine headache documentation), Topamax 50 mg #30 is not medically necessary.

**Qualaquin 325mg #30: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmed/18454580>.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.webmd.com/drugs/2/drug-144700/qualaquin+oral/details>.

**Decision rationale:** Pursuant to Web M.D., Qualaquin 325 mg is not medically necessary. Qualaquin is a medication used for the treatment or prevention of nocturnal leg cramps. This medication may result in serious and life-threatening hematologic reactions including thrombocytopenia and hemolytic uremic syndrome/thrombotic thrombocytopenic program. The risk associated with this drug in the absence of evidence of its effectiveness in the treatment or prevention of nocturnal leg cramps outweighs any potential benefit. In this case, the injured worker's working diagnoses are left shoulder internal derangement; status post left knee replacement; urinary voiding difficulty; constipation; depression and anxiety; left foot sprain secondary to unstable gait; status post right shoulder rotator cuff tear 2011. Qualaquin was first prescribed March 14, 2014. The documentation indicates Qualaquin was prescribed for severe nocturnal right leg cramping due to lumbar spine disease with radiculopathy. The peer-review guidelines state the risk associated with this drug in the absence of evidence of effectiveness in the treatment of nocturnal leg cramps outweighs any potential benefit. Additionally, Qualaquin was prescribed for severe nocturnal right leg cramping due to lumbar spine disease with radiculopathy. This is not an appropriate indication for Qualaquin. Consequently, absent clinical documentation with objective functional improvement with an appropriate clinical indication and the inherent risk associated with the drug, Qualaquin 325 mg is not medically necessary.

**Oxycontin 10mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opiates Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Opiates.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, OxyContin 10 mg #60 is not medically necessary. Ongoing, chronic opiate use requires an ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. A detailed pain assessment should accompany ongoing opiate use. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function or improve quality of life. The lowest possible dose should be prescribed to improve pain and function. In this case, the injured worker's working diagnoses are left shoulder internal derangement; status post left knee replacement; urinary voiding difficulty; constipation; depression and anxiety; left foot sprain secondary to unstable gait; status post right shoulder rotator cuff tear 2011. The treating physician prescribed OxyContin as far back as November 26, 2013. The documentation does not contain evidence of objective functional improvement with ongoing OxyContin 10 mg use. Additionally, the injured worker continues to have subjective complaints of pain. Consequently, absent compelling clinical documentation with objective functional improvement to support the ongoing use of OxyContin 10 mg, OxyContin 10 mg #60 is not medically necessary.