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| Case Number: | CM15-0040909 | | |
| Date Assigned: | 03/11/2015 | Date of Injury: | 12/19/2013 |
| Decision Date: | 05/06/2015 | UR Denial Date: | 02/02/2015 |
| Priority: | Standard | Application Received: | 03/04/2015 |

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: New York
Certification(s)/Specialty: Anesthesiology

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 49 year old male, who sustained an industrial injury on December 19, 2013. The injured worker had reported a neck and left shoulder injury related to a motor vehicle accident. The diagnoses have included displaced cervical intervertebral disc, cervical degenerative disc disease, cervical spondylosis, brachial neuritis or radiculitis and status post rotator cuff repair. Treatment to date has included medications, radiological studies and cervical epidural steroid injections. Current documentation dated January 12, 2015 notes that the injured worker complained of chronic neck pain, left shoulder pain and left forearm pain and paresthesia. Physical examination of the cervical spine revealed pain and a limited range of motion. Left shoulder examination revealed a limited range of motion. A Hawkins Kennedy test was negative. The treating physician's recommended plan of care included requests for the medications Norco, Butrans, Gabapentin, Ambien and Valium.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 mg: Upheld

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): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to MTUS and ODG, Norco 10/325mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. Medical necessity of the increase in this requested medication has not been established. The requested increase in medication is not medically necessary.

Butrans: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Buprenorphine for chronic pain.

Decision rationale: Butrans (Buprenorphine) transdermal patches are used to treat moderate to severe chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. Importantly, there is no requested dosage of this medication documented. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opiate analgesic should include a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

Gabapentin: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 17-19, 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Gabapentin.

Decision rationale: According to the CA MTUS (2009) and ODG, Neurontin (Gabapentin) is an anti-epilepsy drug, which has been considered a first-line treatment for neuropathic pain. This patient has a history of a displaced cervical intervertebral disc, cervical degenerative disc disease, cervical spondylosis, brachial neuritis/radiculitis, and status post left rotator cuff repair. Gabapentin was requested, however, there was no rationale documented for the need for additional medication. In addition, there was no documentation of the dosage or quantity of Gabapentin requested. Medical necessity has not been established. The requested medication is not medically necessary.

Ambien: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Insomnia Treatment.

Decision rationale: Ambien (Zolpidem) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term treatment of insomnia (usually two to six weeks) and is rarely recommended for long-term use. It can be habit-forming, and may impair function and memory more than opioid analgesics, and may increase pain and depression over the long-term. The treatment of insomnia should be based on the etiology and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. In this case, there was no documentation regarding a comprehensive work-up regarding potential sources of the patient's insomnia prior to prescribing a hypnotic, such as Ambien. There is no documentation provided indicating medical necessity for Ambien. The requested medication is not medically necessary.

Valium: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Benzodiazepines.

Decision rationale: According to CA MTUS Guidelines, benzodiazepines are prescribed for anxiety. They are not recommended for long-term use for the treatment of chronic pain because long-term efficacy is unproven and there is a risk of dependency. Valium (Diazepam) is a long-acting benzodiazepine, having anxiolytic, sedative, muscle relaxant, anticonvulsant, and hypnotic properties. Most guidelines recommend the use of Valium for the treatment of anxiety disorders, and as an adjunct treatment for anxiety associated with major depression. In this case, the medication appears to be requested prior to an MRI as a pre-medication. However, there was no

documentation of the dosage or quantity of Valium requested. Medical necessity has not been established. The requested medication is not medically necessary.