MAXIMUS Federal Services

Case Number:	CM15-0047844		
Date Assigned:	03/19/2015	Date of Injury:	11/28/2006
Decision Date:	05/11/2015	UR Denial Date:	02/18/2015
Priority:	Standard	Application Received:	03/13/2015

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, Arizona
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:

The injured worker is a 51-year-old female who reported an injury on 11/28/2006. Her diagnoses were noted as low back, right knee, and right hip pain. During the assessment on 03/03/2015, the injured worker had multiple complaints related to her right lower extremity. There was pain in the right knee, with no swelling. She also complained of groin pain. The physical examination performed on 02/9/2015, revealed palpable tenderness on the 2nd and 3rd toe areas, to the right and left and foot. The pain in the left foot was greater than the right foot. The treatment plan and rationale for the request was not provided. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective: Gabapentin 300mg #90 (DOS: 12/11/2014): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-18.

Decision rationale: The retrospective request for gabapentin 300 mg #90, date of service 12/11/2014, is not medically necessary. The California MTUS Guidelines recommend antiepilepsy medication as a first line medication for the treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30% to 50%, and objective functional improvement. The clinical documentation did not indicate that there was an objective decrease in pain with the use of gabapentin of at least 30% to 50%, or documented objective functional improvement. Additionally, the frequency was not provided. As such, the ongoing use is not supported. Given the above, the request is not medically necessary.

Retrospective: Pamelor 10mg #60 (DOS: 12/11/2014): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13.

Decision rationale: The retrospective request for Pamelor 10 mg #60, date of service 12/11/2014, is not medically necessary. The California MTUS Guidelines recommend antidepressants as a first line medication for treatment of neuropathic pain, and they are recommended especially if pain is accompanied by insomnia, anxiety, or depression. There should be documentation of an objective decrease in pain and objective functional improvement to include an assessment of the changes in the use of other analgesic medications, sleep quality and duration, and psychological assessments. The clinical documentation did not indicate that the injured worker's pain was accompanied by insomnia, anxiety, or depression. There was no documentation of an objective decrease in pain or objective functional improvement with the use of the medication. Additionally, the frequency was not provided. As such, the request is not medically necessary.

Retrospective: Ambien 12.5mg #30 (DOS: 12/11/2014): 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 (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, Zolpidem (Ambien).

Decision rationale: The retrospective request for Ambien 12.5 mg #30, date of service 12/11/2014, is not medically necessary. The Official Disability Guidelines state that zolpidem is a prescription short acting nonbenzodiazepine hypnotic, which is recommended for short-term (7 to 10 days) treatment of insomnia. However, the clinical documentation did not indicate that the injured worker suffered from insomnia. The clinical documentation also provided evidence that the injured worker had been using the medication for an extended duration of time. Additionally, the frequency was not provided. As such, the request is not medically necessary.

Retrospective: Valium 10mg #90 (DOS: 12/11/2014): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines, Weaning of Medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The retrospective request for Valium 10 mg #90, date of service 12/11/2014, is not medically necessary. The California MTUS Guidelines do not recommend the use of benzodiazepines a treatment for patients with chronic pain for longer than 4 weeks due to the high risk of psychological and physiological dependency. The clinical documentation submitted provided evidence that the injured worker had been on this medication for an extended duration of time. Additionally, the frequency was not provided. As such, the ongoing use is not medically necessary.

Retrospective: Soma 350mg #60 (DOS: 12/11/2014): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma), Weaning of Medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Page(s): 29.

Decision rationale: The retrospective request for Soma 350 mg #60, date of service 12/11/2014, is not medically necessary. The California MTUS Guidelines do not recommend Soma, as the medication is not indicated for long-term use. However, the clinical documentation provided evidence that the injured worker had been on this medication for an extended duration of time. Additionally, the frequency was not provided. As such, the request is not medically necessary.