MAXIMUS Federal Services

Case Number:	CM15-0071356		
Date Assigned:	04/21/2015	Date of Injury:	06/27/2003
Decision Date:	08/05/2015	UR Denial Date:	03/30/2015
Priority:	Standard	Application Received:	04/14/2015

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: 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 48-year-old male, who sustained an industrial injury on 6/27/2003. The medical records submitted for this review did not include details regarding the initial injury. Diagnoses include chronic pain, lumbar radiculopathy, right hip pain, right knee pain, failed hip surgery x 4, and failed back surgery x 2. Treatments to date include medication therapy, activity modification, acupuncture, and TENS unit. There is history of a failed spinal cord stimulator trial resulting in no relief in pain and numbness and weakness of bilateral lower extremities. Currently, he complained of low back pain with radiation down bilateral lower extremities and associated with muscle weakness. There was pain in bilateral pain worsened with activity and walking. Pain was rated 8/10 with medication and 10/10 without medication. On 3/10/15, the physical examination documented tenderness of lumbar spine with limited range of motion due to pain with decreased strength noted. The plan of care included continuation of medication therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) prescription of Naprosyn 500mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-Selective NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67.

Decision rationale: As per MTUS Guidelines Naproxen is a non-steroidal NSAIDs. This type of medication is recommended for the treatment of chronic pain as a second line of therapy after acetaminophen. The documentation indicates the patient has been maintained on long-term NSAID therapy and there has been no compelling evidence presented by the provider to document that the patient has had any functional improvements from this medication. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

One (1) prescription of Cyclobenzaprine 10mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-65. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter - Muscle relaxants.

Decision rationale: According to the reviewed literature, Cyclobenzaprine (Flexeril) is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. In addition, this medication is not recommended to be used for longer than 2-3 weeks. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. In this case, the available medical records do not show if the injured worker has shown a documented benefit or any functional improvement from prior Cyclobenzaprine use. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested treatment is not medically necessary.

One (1) prescription of Neurontin 600mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-20, 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter-Antiepilepsy drugs (AEDs).

Decision rationale: According to the CA MTUS (2009) and ODG, Neurontin (Gabapentin) is an anti-epilepsy drug, which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia, and has been considered as a first-line treatment for neuropathic pain. The records documented that this injured worker has neuropathic pain related

to her chronic low back condition. Neurontin has been part of her medical regimen. However In this case, there is no compelling evidence presented by the treating provider that indicates this injured worker has had any significant improvements from this medication, and also review of Medical Records do not clarify that previous use of this medication has been effective in this injured worker for maintaining the functional improvement. Medical necessity for Neurontin has not been established. The requested medication is not medically necessary.

One (1) prescription of Tramadol 50mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ultram (tramadol) Page(s): 75-82.

Decision rationale: According to the California MTUS, Tramadol (Ultram) is a synthetic opioid, which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. According to the medical records, there has been no documentation of the medication's analgesic effectiveness and no clear documentation that the patient has responded to ongoing opioid therapy. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic requires a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

One (1) prescription of 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), 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 Chapter--Insomnia Treatment.

Decision rationale: Ambien (Zolpidem) is a prescription short-acting non-benzodiazepine hypnotic, which is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Ambien can be habit-forming, and may impair function and memory more than opioid analgesics. There is also concern that Ambien 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, the injured worker has chronic pain, and the submitted documentation does not indicate

that Ambien has helped this injured worker. The requested medication is not medically necessary.

Eight (8) sessions of acupunture: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: This prescription for acupuncture is evaluated in light of the MTUS recommendations for acupuncture. The MTUS recommends an initial trial of 3-6 visits of acupuncture. Per the MTUS, "acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery". Medical necessity for any further acupuncture is considered in light of "functional improvement". There is evidence that this injured worker has received treatments with acupuncture before, but there is no documentation of functional improvement that would support continuation of this request. Given the MTUS recommendations for use of acupuncture, the prescription for 8 sessions is not medically necessary.