

Case Number:	CM14-0114570		
Date Assigned:	08/04/2014	Date of Injury:	02/21/2000
Decision Date:	11/19/2014	UR Denial Date:	07/14/2014
Priority:	Standard	Application Received:	07/22/2014

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. The expert reviewer is Board Certified in Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 64-year-old man who sustained a work-related injury on February 21, 2000. Subsequently, he developed low back and bilateral leg pain. According to the progress report dated June 2, 2014, the patient complained of persistent back and bilateral leg pain. He stated that his symptoms are increasing, especially with prolonged standing and walking. He stated that he does have spasm. He stated that his medications do help but are no longer relieving his symptoms and affects his activities of daily living. Physical examination demonstrated that the patient had an antalgic gait on the right. There was tenderness about the lumbar paraspinal muscles and thoracic paraspinal muscles. There was spasm noted with motion. The patient was able to flex to 35 degrees and extend to 15 degrees. Rotation was 40 degrees. Lateral bending was 20 degrees. There was decreased sensation about the L5 dermatomes, bilaterally. There was 5/5 muscle strength in all major muscle groups in the patient's lower extremities. Lower extremities reflexes were 2+ bilateral and symmetrical. The patient was diagnosed with L3-4 junctional syndrome status post L4 to S1 fusion and depression. The provider requested authorization for Hydrocodone / APAP, Zolpidem, and Naproxen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone / APAP 10/325mg - Tab PO every 6-8 hours PRN: #30: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Opioids, specific drug list, Hydrocodone / Acetaminophen.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Criteria for use of opioids, page(s) 179.

Decision rationale: According to MTUS guidelines, Norco (Hydrocodone/Acetaminophen) is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework. There is no clear justification for the need to continue the use of Hydrocodone. The patient was treated with Hydrocodone without any evidence of pain and functional improvement, compliance and monitoring of side effects. Therefore, the prescription of Hydrocodone/APAP tab 10/325mg is not medically necessary.

Zolpidem 10mg - 1 tab PO every night #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) - TWC, Online Edition, Chapter: Pain, Zolpidem (Ambien)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Non-Benzodiazepine sedative-hypnotics (Benzodiazepine-receptor agonists (<http://worklossdatainstitute.verioiponly.com/odgtwc/pain.htm> >.

Decision rationale: Zolpidem is a non-benzodiazepine hypnotic agent that is a Pyrolopyrazine derivative of the Cyclopyrrolone class. According to MTUS guidelines, tricyclic antidepressants are recommended as a first line option in neuropathic pain, especially if pain is accompanied by insomnia, anxiety or depression. According to ODG Guidelines, Non-Benzodiazepine sedative-hypnotics (Benzodiazepine-receptor agonists): First-line medications for insomnia. This class of medications includes Zolpidem (Ambien and Ambien CR), Zaleplon (Sonata), and Eszopiclone (Lunesta). Benzodiazepine-receptor agonists work by selectively binding to type-1 benzodiazepine receptors in the CNS. All of the benzodiazepine-receptor agonists are schedule IV controlled substances, which mean they have potential for abuse and dependency. In this patient, there is no clear documentation of insomnia that justifies the long-term use of Zolpidem. There is no documentation of sleep study that better characterize the patient insomnia. There is

no periodic objective documentation of the effect of previous use of Zolpidem on the sleep quality and the patient functionality. Zolpidem could be used as an option to treat insomnia after failure of first line medications and non-pharmacologic therapies; however it should not be used for a long-term without periodic evaluation of its need. Therefore, the prescription of Zolpidem 10 mg is not medically necessary.

Naproxen 550g - 1 tab PO every 12 hours #100: 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 NON SELECTIVE NSAIDS Page(s): 72..

Decision rationale: Naproxen (Naprosyn): delayed release (EC-Naprosyn), as Sodium salt (Anaprox, Anaprox DS, Aleve [OTC]) Generic available; extended-release (Naprelan): 375 mg. Different dose strengths and formulations of the drug are not necessarily bioequivalent. Dosing Information: Osteoarthritis or Ankylosing spondylitis: Dividing the daily dose into 3 doses versus 2 doses for immediate-release and delayed-release formulations generally does not affect response. Morning and evening doses do not have to be equal in size. The dose may be increased to 1500 mg/day of Naproxyn for limited periods when a higher level of analgesic/anti-inflammatory activity is required (for up to 6 months). Naprosyn or Naproxyn: 250-500 mg PO twice daily. Anaprox: 275-550 mg PO twice daily. (Total dose may be increased to 1650 mg a day for limited periods). EC-Naprosyn: 375 mg or 500 mg twice daily. The tablet should not be broken, crushed or chewed to maintain integrity of the enteric coating. Naprelan: Two 375 mg tablets (750 mg) PO once daily or two 500 mg tablets (1000 mg) once daily. If required (and a lower dose was tolerated) Naprelan can be increased to 1500 mg once daily for limited periods (when higher analgesia is required). Pain: Naprosyn or Naproxyn: 250-500 mg PO twice daily. The maximum dose on day one should not exceed 1250 mg and 1000 mg on subsequent days. Anaprox: 275-550 mg PO twice daily. The maximum dose on day one should not exceed 1375 mg and 1100 mg on subsequent days. Extended-release Naprelan: Not recommended due to delay in absorption. (Naprelan). There is no documentation of the rationale behind the long-term use of Naproxen. NSAID should be used for the shortest duration and the lowest dose. There is no documentation from the patient file that the provider titrated Naproxen to the lowest effective dose and used it for the shortest period possible. Naproxen was used without clear documentation of its efficacy. Furthermore, there is no documentation that the provider followed the patient for NSAID adverse reactions that are not limited to GI side effect, but also may affect the renal function. Therefore, the request for Naproxen 550MG #100 is not medically necessary.