

Case Number:	CM14-0179591		
Date Assigned:	11/04/2014	Date of Injury:	09/25/2007
Decision Date:	12/09/2014	UR Denial Date:	10/20/2014
Priority:	Standard	Application Received:	10/29/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in California. 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:

According to the records made available for review, this is a 55-year-old female with a 9/25/07 date of injury. At the time (9/24/14) of request for authorization for Ambien 10 mg QTY 30, Lidoderm 5 Percent QTY 90, Norflex ER 100 mg QTY 90, Protonix 20 mg QTY 60, Norco 5/325 mg QTY 90, Neurontin 300 mg QTY 90, and Ultram ER 150 mg QTY 30, there is documentation of subjective (low back pain) and objective (not specified) findings, current diagnoses (chronic pain, major depressive disorder, thoracic/lumbosacral neuritis/radiculitis, and degenerative lumbar/lumbosacral intervertebral disc), and treatment to date (medications (including ongoing treatment with Lexapro, Protonix, Ultram, Cyclobenzaprine, Norco, Neurontin, Lidoderm patch, Naproxen, and Senokot)). Regarding Ambien, there is no documentation of insomnia. Regarding Lidoderm patch, there is no documentation that a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica) has failed; and of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Lidoderm patch use to date. Regarding Norflex, there is no documentation of short-term (less than two weeks) treatment. Regarding Protonix, there is no documentation of risk for gastrointestinal events, preventing gastric ulcers induced by NSAIDs, and that Protonix is being used as a second-line treatment. Regarding Norco and Ultram, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Norco and Ultram use to date. Regarding Neurontin, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an

increase in activity tolerance; and/or a reduction in the use of medications as a result of Neurontin use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10 MG Qty 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)

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

Decision rationale: MTUS does not address this issue. ODG identifies Ambien (Zolpidem) as a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Within the medical information available for review, there is documentation of diagnoses of chronic pain, major depressive disorder, thoracic/lumbosacral neuritis/radiculitis, and degenerative lumbar/lumbosacral intervertebral disc. However, there is no documentation of insomnia. Therefore, based on guidelines and a review of the evidence, the request for Ambien 10 mg QTY 30 is not medically necessary.

Lidoderm 5 Percent Qty 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56-57.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain after there has been evidence that a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica) has failed, as criteria necessary to support the medical necessity of a Lidocaine patch. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of chronic pain, major depressive disorder, thoracic/lumbosacral neuritis/radiculitis, and degenerative lumbar/lumbosacral intervertebral disc. In addition, there is documentation of neuropathic pain. However, there is no documentation that a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica) has failed. In addition, given documentation of ongoing treatment with Lidoderm patch, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of

medications as a result of Lidoderm patch use to date. Therefore, based on guidelines and a review of the evidence, the request for Lidoderm 5 Percent QTY 90 is not medically necessary.

Norflex ER 100 MG Qty 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-64.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of acute exacerbation of chronic low back pain and used as a second line option for short-term treatment, as criteria necessary to support the medical necessity of muscle relaxant. ODG identifies that muscle relaxants are recommended for short-term (less than two weeks) treatment. Within the medical information available for review, there is documentation of diagnoses of chronic pain, major depressive disorder, thoracic/lumbosacral neuritis/radiculitis, and degenerative lumbar/lumbosacral intervertebral disc. In addition, given documentation of ongoing treatment with NSAID, there is documentation of Norflex used as a second line agent. However, there is no documentation of acute muscle spasms or acute exacerbation of chronic low back pain. In addition, given a request of Norflex ER 100 mg QTY 90, there is no documentation of short-term (less than two weeks) treatment. Therefore, based on guidelines and a review of the evidence, the request for Norflex ER 100 mg QTY 90 is not medically necessary.

Protonix 20 MG Qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitors (PPIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Proton pump inhibitors (PPIs) Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that risk for gastrointestinal event includes age > 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; and/or high dose/multiple NSAID. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of risk for gastrointestinal events, preventing gastric ulcers induced by NSAIDs, and that Protonix is being used as a second-line, as criteria necessary to support the medical necessity of Protonix. Within the medical information available for review, there is documentation of diagnoses of chronic pain, major depressive disorder, thoracic/lumbosacral neuritis/radiculitis, and degenerative lumbar/lumbosacral intervertebral disc. However, there is no documentation of risk for gastrointestinal events, preventing gastric ulcers induced by

NSAIDs, and that Protonix is being used as a second-line treatment. Therefore, based on guidelines and a review of the evidence, the request for Protonix 20 mg QTY 60 is not medically necessary.

Norco 5/325 MG Qty 90:

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of chronic pain, major depressive disorder, thoracic/lumbosacral neuritis/radiculitis, and degenerative lumbar/lumbosacral intervertebral disc. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, given documentation of ongoing treatment with Norco, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Norco use to date. Therefore, based on guidelines and a review of the evidence, the request for Norco 5/325 mg QTY 90 is not medically necessary.

Neurontin 300 MG Qty 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 18-19. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain, as criteria necessary to support the medical necessity of Neurontin (Gabapentin). MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or

medical services. Within the medical information available for review, there is documentation of diagnoses of chronic pain, major depressive disorder, thoracic/lumbosacral neuritis/radiculitis, and degenerative lumbar/ lumbosacral intervertebral disc. In addition, there is documentation of neuropathic pain and ongoing treatment with Gabapentin. However, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Neurontin use to date. Therefore, based on guidelines and a review of the evidence, the request for Neurontin 300 mg QTY 90 is not medically necessary.

Ultram ER 150 MG Qty 30: 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): 74-80; 113. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; as criteria necessary to support the medical necessity of Opioids. In addition, specifically regarding Tramadol, MTUS Chronic Pain Medical Treatment Guideline identifies documentation of moderate to severe pain and Tramadol used as a second-line treatment (alone or in combination with first-line drugs), as criteria necessary to support the medical necessity of Tramadol. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of chronic pain, major depressive disorder, thoracic/lumbosacral neuritis/radiculitis, and degenerative lumbar/lumbosacral intervertebral disc. In addition, there is documentation of pain. Furthermore, given documentation of ongoing treatment with NSAID, there is documentation of Ultram used as a second-line treatment (in combination with first-line drugs). However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, given documentation of ongoing treatment with Ultram, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Ultram use to date. Therefore, based on guidelines and a review of the evidence, the request for Ultram ER 150 mg QTY 30 is not medically necessary.