

Case Number:	CM14-0214680		
Date Assigned:	01/07/2015	Date of Injury:	02/07/2000
Decision Date:	02/28/2015	UR Denial Date:	11/28/2014
Priority:	Standard	Application Received:	12/22/2014

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. 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
 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 patient is a 56 year old female with an injury date of 02/07/00. Based on the 11/06/14 progress report provided by treating physician, the patient complains of low back pain radiating to lower extremities rated at 7/10. Physical examination to the back revealed tenderness to the paraspinals. Range of motion was decreased. Patient has had 2 injections in the past. Patient as had 3 PSTIM treatments. Per treater's report dated 11/06/14, the patient is permanent and Stationary. Diagnosis (11/06/14)- Mild right L3/4 radiculopathy- Right L5 radiculitis improving post epidural injection- L4/5 degenerative disc disease with foraminal narrowing- Degenerative joint disease right hip joint- Status post right acetabular fracture requiring ORIF in 1978 per patient history The utilization review determination being challenged is dated 11/28/14. The rationale follows: 1) 30 NUVIGIL 150MG: "failed to indicate this patient has narcolepsy or shift work sleep disorder... appears to be prescribed to offset the effets of other prescribed medications;" 2) 60 CARISOPRODOL 350MG: guidelines do not recommend this muscle relaxant for long-term use." 3) 30 ZOLPIDEM 10MG: "recommended for short-term treatment" 4) 30 RANITINE 150MG: "the records do not indicate that the patient suffered with GERD from any source." Treatment reports were provided from 12/09/13 to 12/18/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

30 Nuvigil 150mg: 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)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG) chapter 'Pain (chronic), Armodafinil (Nuvigil).

Decision rationale: The patient presents with low back pain radiating to lower extremities rated at 7/10. The request is for 30 NUVIGIL 150MG. Patient has had 2 injections in the past. Patient as had 3 PSTIM treatments. Patient is P & S.ODG Guidelines, chapter 'Pain (chronic)' and topic 'Armodafinil (Nuvigil)', have the following regarding Provigil (Modafinil): "Not recommended solely to counteract sedation effects of narcotics." Modafinil is used to treat excessive sleepiness caused by narcolepsy, obstructive sleep apnea or shift work sleep disorder. It is very similar to Amodafinil. Studies have not demonstrated any difference in efficacy and safety between armodafinil and modafinil. Treater has not provided reason for the request. Per UR letter dated 11/28/14, "a 10/24/14 narrative report regarding medication management" was submitted by treater. However, that same 10/24/14 report along with any other documentation regarding the patient's medication usage discussion was not submitted for review. Furthermore, submitted documentation does not support excessive sleepiness. Therefore, given the lack of documentation, the request IS NOT medically necessary.

60 Carisoprodol 350mg: 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 Page(s): 63-66.

Decision rationale: The patient presents with low back pain radiating to lower extremities rated at 7/10. The request is for 60 CARISOPRODOL 350MG. Patient has had 2 injections in the past. Patient as had 3 PSTIM treatments. Patient is P & S. Treater has not provided reason for the request. Per UR letter dated 11/28/14, "a 10/24/14 narrative report regarding medication management" was submitted by treater. However, that same 10/24/14 report along with any other documentation regarding the patient's medication usage discussion was not submitted for review. Per UR letter dated 11/28/14, "the patient has used carisoprodol since at least 2009." MTUS recommends Carisoprodol only for a short period. Carisoprodol was prescribed at least for 5 years from the UR date of 11/28/14. Furthermore, the request for a quantity 60 does not indicate intended short-term use of this medication. Therefore, the request is not medically necessary.

30 Zolpidem 10mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

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 for Ambien.

Decision rationale: The patient presents with low back pain radiating to lower extremities rated at 7/10. The request is for 30 ZOLPIDEM 10MG. Patient has had 2 injections in the past. Patient as had 3 PSTIM treatments. Patient is P & S. Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Longer-term studies have found Ambien CR to be effective for up to 24 weeks in adults. Adults who use Zolpidem have a greater than 3-fold increased risk for early death, according to results of a large matched cohort survival analysis."Treater has not provided reason for the request. Per UR letter dated 11/28/14, "a 10/24/14 narrative report regarding medication management" was submitted by treater. However, that same 10/24/14 report along with any other documentation regarding the patient's medication usage discussion was not submitted for review. Per UR letter dated 11/28/14, "the patient has been prescribed Ambien sine at least 2012, and as far back as 2006." ODG recommends Zolpidem only short-term, due to negative side effect profile. Zolpidem was prescribed for more than 2 years or longer from the UR date of 11/28/14. Furthermore, the request for a quantity 30 does not indicate intended short-term use of this medication. Therefore, the request is not medically necessary.

30 Ranitidine 150mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation New Zealand Guidelines Group (NZGG). Management of dyspepsia and heartburn. Wellington (NZ): New Zealand Guidelines Group (NZGG); 2004 Jun. 119 p

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk. Page(s): 68-69.

Decision rationale: The patient presents with low back pain radiating to lower extremities rated at 7/10. The request is for 30 RANITINE 150MG. Patient has had 2 injections in the past. Patient as had 3 PSTIM treatments. Patient is P & S. MTUS pg. 69 states, "Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)." "Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." Treater has not provided reason for the request. Per UR letter dated 11/28/14, "a 10/24/14 narrative report regarding medication management" was submitted by treater. However, that same 10/24/14 report along with any other documentation regarding the patient's medication usage discussion was not submitted for review. Available reports do not discuss the patient's risk assessment, whether or not the patient is on any oral NSAIDs. There are no discussion regarding patient's GI issues. Given the lack of documentation, the request is not medically necessary.

