

Case Number:	CM15-0008702		
Date Assigned:	01/26/2015	Date of Injury:	01/02/2006
Decision Date:	05/11/2015	UR Denial Date:	12/16/2014
Priority:	Standard	Application Received:	01/15/2015

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: Pediatrics, 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:

This 55-year-old male sustained work-related injuries to his neck and back on 1/2/2006. The date of injury according to the IW's representative is 12/23/2005 and is noted as 12/28/2005 in the PR2 dated 5/28/2014. Diagnoses include cervical and lumbosacral radiculopathy, brachial neuritis or radiculitis, NOS, hand sprain/strain, shoulder tendonitis/bursitis, wrist tendonitis/bursitis and knee sprain/strain. Previous treatments as per the "Follow-Up for Primary Treating Physician, Request for Authorization, Appeal to UR and Procedure Note" include medications, external bone stimulator, physical therapy and spinal fusion. The treating provider requests one unknown prescription for each of the following medications: Neurontin, Norco, Ambien and Paxil. The Utilization Review on 12/16/2014 non-certified the request for Neurontin; Norco, Ambien and Paxil were modified to one prescription each of Norco 7.5 mg #90, Ambien 5 mg #30 and Paxil 20 mg #30. References cited were ODG Low Back-Lumbar and Thoracic (Acute and Chronic) and CA MTUS Chronic Pain Medical Treatment Guidelines for Long-term Users of Opioids.

IMR ISSUES, DECISIONS AND RATIONALES

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

Unknown prescription of Neurontin: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 15-19.

Decision rationale: Gabapentin is recommended on a trial basis with lumbar spinal stenosis to assess if there is improved sensation, decreased pain with movement and increased walking distance. There was no documentation of objective functional benefit with prior use of these medications. The request is not medically necessary and appropriate.

Unknown prescription of Norco: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiods, criteria for use 4) On-Going Management Page(s): 78.

Decision rationale: The IW has been on long term opiods which is not recommended. Additionally, documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. This request is not medically necessary and reasonable at this time.

Unknown prescription of Ambien: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Insomnia Treatment.

Decision rationale: Per ODG pharmacological agents for insomnia should only be used after careful evaluation of potential causes of sleep disturbance for the etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. There is no discussion of an investigation into the origin of the sleep disturbance and non-pharmacological interventions that may have been utilized. This request is not appropriate

Unknown prescription of Paxil: 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 Antidepressants for chronic pain Page(s): 13-16.

Decision rationale: Per MTUS guidelines, antidepressants are recommended as a first line option for neuropathic pain. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. There is no notation in the medical records of the IW failing a first line agent. Additionally, Paxil is a SSRI and more information is needed regarding the role of SSRIs and pain before a recommendation can be made. The request is not medically necessary and appropriate.