

Case Number:	CM15-0018726		
Date Assigned:	02/06/2015	Date of Injury:	11/23/2012
Decision Date:	03/30/2015	UR Denial Date:	01/14/2015
Priority:	Standard	Application Received:	02/02/2015

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: 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 injured worker is a 52 year old male who sustained an industrial related injury on 11/23/12. The injured worker had complaints of left hip and left thigh pain. Physical examination findings included left hip pain with decreased range of motion. Diagnoses included left hip derangement. Treatment included physical therapy and acupuncture treatments. The treating physician requested authorization for Norco 10/325 #180, Neurontin 300mg #90, and Ambien 10mg #30. On 1/14/15 the requests were non-certified. Regarding Norco and Neurontin, the utilization review (UR) physician cited the Medical Treatment Utilization Schedule (MTUS) guidelines and noted there was no documented symptomatic or functional improvement from previous usage. Therefore the requests were non-certified. Regarding Ambien, the UR physician cited the Official Disability Guidelines and noted there was no explicit documentation of current sleep disturbance, results of sleep behavior modification attempts, or documentation of failed trials of other guideline-supported treatments. Therefore the request was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for Chronic Pain Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: The patient presents with pain in his left hip and left thigh. The request is for NORCO 10/325MG #180. The patient is currently taking Norco, Neurontin and Ambien. The patient has been utilizing Norco since at least 09/18/14. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4 A's --analgesia, ADLs, adverse side effects, and adverse behavior--, as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work, and duration of pain relief. MTUS guidelines page 90 states that "Hydrocodone has a recommended maximum dose of 60mg/24 hours." The review of the reports shows that the treater has addressed urine drug screening on 10/16/14 that the patient was positive for opiates. None of the reports discuss this medication's efficacy. The four A's including analgesia, ADL's, side effects, and other measures of aberrant drug seeking behavior are not addressed as required by MTUS for chronic opiate use. There are no before and after pain scales to show analgesia; no specific ADL's are mentioned to show functional improvement. Given the lack of sufficient documentation demonstrating efficacy for chronic opiate use, the patient should slowly be weaned as outlined in MTUS guidelines. The request IS NOT medically necessary.

Neurontin 300mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy Drugs (AEDs) Page(s): 16-22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 18-19.

Decision rationale: The patient presents with pain in his left hip and left thigh. The request is for NEURONTIN 300MG #90. MTUS guidelines page 18 and 19 states that "'Gabapentin -- Neurontin, Gabarone, generic available-- has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain." In this case, the patient has been utilizing Neurontin since at least 09/18/14. The treater does not provide adequate documentation of pain reduction or functional improvement from the use of this medication. MTUS require documentation of at least 40% reduction of pain with initial trial for chronic use of this medication. MTUS page 60 require recording of pain and function when medication is used for chronic pain. The requested Neurontin IS NOT medically necessary.

Ambien 10mg #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), Chronic Pain, Zolpidem (Ambien)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Pain chapter, Zolpidem;Insomnia treatment

Decision rationale: The patient presents with pain in his left hip and left thigh. The request is for AMBIEN 10MG #30. ODG guidelines, Drug Formulary, have the following regarding Ambien for insomnia: "Zolpidem --Ambien --generic available--, Ambien CR-- 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. Longer-term studies have found Ambien CR to be effective for up to 24 weeks in adults." In this case, the patient has been suffering from insomnia for which this medication may be indicated. However, there is no indication that this medication is to be used for a short-term. The review of the reports shows that the patient has been utilizing Ambien since at least 10/16/14. The ODG guidelines support only short-term use of this medication, in most situations no more than 7-10 days. The request IS NOT medically necessary.