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| Case Number: | CM15-0171403 | | |
| Date Assigned: | 09/11/2015 | Date of Injury: | 12/17/1989 |
| Decision Date: | 10/09/2015 | UR Denial Date: | 07/27/2015 |
| Priority: | Standard | Application Received: | 08/31/2015 |

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: Arizona, California
 Certification(s)/Specialty: Family Practice

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 58 year old female who sustained an industrial injury on 12-17-1989. Current medical problems include lumbar degenerative disc disease, rule out left lumbar radiculopathy, and rule out lumbar facet disorder, emotional factors, and severe chronic pain syndrome. Report dated 06-25-2015 noted that the injured worker presented with complaints that included low back and leg pain. Pain level was 8 out of 10 on a visual analog scale (VAS). The injured worker "sleep 6-8 hours per night." Current medications include Norco, Toprol, HCTZ, zolpidem, aspirin, ibuprofen, omeprazole, Gralise, and ranitidine. Physical examination performed on 06-25-2015 revealed positive straight leg raise on the left and decreased grip strength on left when compared to the right. Previous treatments included medications. The treatment plan included continued use of Norco, zolpidem, Gralise, and request for an expedited consultation with a specialist. The injured worker was first prescribed Zantac (ranitidine) on 03-23-2015 due to gastritis related to use of Gralise. The injured worker has been prescribed zolpidem since at least 02-23-2015. The utilization review dated 07-23-2015, non-certified the request for zolpidem and ranitidine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zolpidem Tertrate Tab 10mg #30 With 3 Refills: 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 and insomnia- pg 64.

Decision rationale: The MTUS guidelines do not comment on insomnia. According to the ODG guidelines, recommend that treatment be based on the etiology, with the medications. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. Zolpidem is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). In this case, the claimant had used the medication for several months. The etiology of sleep disturbance was not defined or further evaluated. Failure of behavioral interventions was not noted. Continued use of Zolpidem (Ambien) with 3 refills is not medically necessary.

Ranitidine Tab 150mg # 60 With 3 Refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs), NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: Ranitidine is an H2 blocker. It is indicated for GERD. Similar to a PPI, it is to be used with for those with high risk of GI events such as bleeding, perforation, and concurrent anticoagulation/anti-platelet use. In this case, there is no documentation of GI events or antiplatelet use that would place the claimant at risk. Te claimant was previously on a PPRI and currently on Ranitidine for several months due to gastritis from Gralise use. There is no indication for continued Gralise use since the claimant does not have diagnoses to support continued use. Therefore, the continued use of Ranitidine is not medically necessary.