

Case Number:	CM15-0065367		
Date Assigned:	04/13/2015	Date of Injury:	05/18/2001
Decision Date:	06/01/2015	UR Denial Date:	03/18/2015
Priority:	Standard	Application Received:	04/06/2015

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: Anesthesiology

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 54 year old male, who sustained an industrial injury on May 18, 2001. He was diagnosed with lumbosacral degenerative disc disease with lumbar stenosis and spondylolisthesis. Treatment included a lumbar fusion, physical therapy, aqua therapy, chiropractic sessions, and pain management. Currently, the injured worker complained of chronic pain to his lower back radiating into the legs and buttocks. The treatment plan that was requested for authorization included prescriptions for Horizant, Baclofen, Latuda, Ambien and Norco.

IMR ISSUES, DECISIONS AND RATIONALES

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

Horizant 600mg quantity unspecified: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Gabapentin. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)
Gabapentin.

Decision rationale: Horizant (Gabapentin Encarbil extended-release tablets) is an anti-epilepsy drug which has been shown to be effective for the treatment of painful diabetic neuropathy and post-herpetic neuralgia, and has been considered as a first-line treatment for neuropathic pain. It is also FDA approved as a second-line option for restless leg syndrome, however, there is no documentation of this for this patient. There is no evidence to support the use of Horizant without a trial of generic Gabapentin regular-release tablets first. Medical necessity for Horizant has not been established. The requested medication is not medically necessary.

Baclofen 10mg quantity 120: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Muscle Relaxants.

Decision rationale: The California MTUS Guidelines and the ODG recommends non-sedating muscle relaxants, such as Baclofen, with caution as a second-line option for short-term treatment of acute low back pain (LBP), and for short-term (<2 weeks) treatment of acute exacerbations in patients with chronic LBP. The mechanism of action is blockade of the pre- and post-synaptic GABA receptors. It is recommended orally for the treatment of spasticity and muscle spasm related to multiple sclerosis and spinal cord injuries. It is also a first-line option for the treatment of dystonia. Baclofen has been noted to have benefits for treating lancinating, paroxysmal neuropathic pain. In this case, there is no documentation provided necessitating the use of Baclofen. There is no evidence of objective functional benefit to support any subjective improvements noted. In addition, the cited guidelines do not recommend this medication to be used for longer than 2-3 weeks. Medical necessity for the requested medication has not been established. The requested item is not medically necessary.

Latuda 80mg quantity 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Atypical antipsychotics.

Decision rationale: Latuda (Lurasidone) is an atypical anti-psychotic. It has been approved for the treatment of depressive episodes associated with bipolar disorder in adults when used alone or in combination with Lithium or Valproate. It is not recommended as a first-line treatment. In this case, there is no documentation that the patient failed other medications addressing mood disorders. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Ambien 10mg quantity 60: Upheld

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

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: Ambien (Zolpidem) is a prescription short-acting non-benzodiazepine hypnotic, which is recommended for short-term treatment of insomnia (two to six weeks). Ambien is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Longer-term studies have found Ambien to be effective for up to 24 weeks in adults. It can be habit-forming, and may impair function and memory more than opioid analgesics. There is also concern that Ambien may increase pain and depression over the long-term. The treatment of insomnia should be based on the etiology, and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. There is no documentation provided indicating medical necessity for Ambien. The requested medication is not medically necessary.

Norco 10/325mg quantity 150: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the CA MTUS and ODG, Norco 10/325mg (Hydrocodone / Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's functional benefit. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.