

Case Number:	CM13-0007124		
Date Assigned:	12/11/2013	Date of Injury:	08/07/1989
Decision Date:	02/11/2014	UR Denial Date:	07/08/2013
Priority:	Standard	Application Received:	08/05/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and Cardiology, has a subspecialty in Cardiovascular Disease, and is licensed to practice in Texas. 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 physician 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/services. He/She is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 51-year-old male who reported a work related injury on 08/07/1989, specific mechanism of injury not stated. The patient presents for treatment of the following diagnoses: degenerative disc disease of the lumbar spine, postlaminectomy with radiculitis down the bilateral lower extremities, multilevel spinal stenoses, worse at the L4-5 level and significant annular tears L4-5, L5-S1. Clinical note dated 04/24/2013 reports the patient was seen under the care of [REDACTED]. The provider documents the patient presents for followup with complaints of lumbar spine pain rated at 6/10. The patient reports slight swelling of the right lower extremity as well as associated numbness at the waistline, bilateral hips, and feet. The provider documents the patient utilizes OxyContin 20 mg 3 times a day, ibuprofen, Vicodin 7.5 three times a day. The provider reported upon physical exam of the patient, decreased range of motion of the lumbar spine upon forward flexion was noted at 60 degrees and extension of 10 degrees. The provider documented recommendations for the patient to undergo electrodiagnostic studies, prescription for ibuprofen 800, and Ambien 10 was administered.

IMR ISSUES, DECISIONS AND RATIONALES

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

One prescription of Motrin 800mg #100 with 3 refills between 4/24/2013 and 9/6/2013:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 72.

Decision rationale: The current request is not supported. Review of the clinical notes from 04/2013 through 09/2013 does not evidence the employee's reports of efficacy with this current medication regimen. The employee continued to report a rate of pain at 6/10 to 7/10. Motrin is an anti-inflammatory utilized as an analgesic for pain complaints, which would be indicated for the employee's current clinical picture. However, 3 refills are excessive in nature without monitoring of the employee's side effects with this medication or efficacy of treatment. Therefore, given the above, the request for 1 prescription of Motrin 800mg #100 with 3 refills between 4/24/2013 and 9/6/2013 is not medically necessary or appropriate.

One prescription of Ambien 20mg #30 with 3 refills between 4/24/2013 and 9/6/2013:
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), Section 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), Pain Chapter.

Decision rationale: The current request is not supported. The clinical documentation submitted for review fails to evidence the employee's sleep pattern complaints, efficacy of utilization of Ambien, and duration of use of this medication. The Official Disability Guidelines indicate this medication is approved for the short-term, usually 2 to 6 weeks treatment of insomnia. Given all the above, the request for 1 prescription of Ambien 20mg #30 with 3 refills between 4/24/2013 and 9/6/2013 is not medically necessary nor appropriate.