

Case Number:	CM13-0016370		
Date Assigned:	11/06/2013	Date of Injury:	10/15/2001
Decision Date:	01/24/2014	UR Denial Date:	07/30/2013
Priority:	Standard	Application Received:	08/26/2013

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 Physical Medicine & Rehabilitation, and is licensed to practice in California. 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 68-year-old male who reported an injury on 10/15/2001. The mechanism of injury was not provided for review. The patient was treated conservatively with physical therapy. The patient underwent a magnetic resonance imaging (MRI) of the lumbar spine that revealed there was a disc bulge causing severe central canal and neural foraminal stenosis at the L3-4 level and L4-5 level with advanced facet degeneration. The patient underwent an electrodiagnostic study that revealed chronic radiculopathy in the bilateral L4-5 distribution. The patient's chronic pain was managed with medications. The patient's most recent clinical evaluation reported that the patient was taking Ambien, Valium, and Lortab. Physical findings included spasms and tenderness to palpation along the paravertebral musculature with a positive left-sided straight leg raising test and decreased sensation over the left lower extremity with spasms. The patient's diagnoses included a herniated disc of the lumbar spine. The patient's treatment plan was to continue medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 7.5/500mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-Going Management Page(s): 78.

Decision rationale: The requested hydrocodone 7.5/500 mg #60 for dates of service between 06/14/2013 and 09/05/2013 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the employee has ongoing lumbosacral pain complaints. The MTUS guidelines recommend that the continued use of opioids in the management of a patient's chronic pain be supported by an assessment of side effects, an assessment of symptom relief, an assessment of functional benefit, and monitoring for aberrant behaviors. The clinical documentation submitted for review does not provide any evidence that the employee has increased functional benefit or pain relief as a result of this medication. Additionally, there is no documentation that the employee has been regularly monitored since 2012 for aberrant behavior. As such, the requested hydrocodone 7.5/500 mg #60 (through Express Scripts) between 06/14/2013 and 09/05/2013 is not medically necessary or appropriate.

Fiorocet #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents Page(s): 23.

Decision rationale: The requested Fioricet #60 between 06/14/2013 and 09/05/2013 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the employee has ongoing lumbar spine complaints. The MTUS guidelines do not recommend the use of barbiturate containing analgesic agents in the management of chronic pain due to a high risk of drug dependence. Additionally, the clinical documentation submitted for review does not provide any functional benefit or assessments of aberrant behavior or symptom response to the requested medication. As such, the requested Fioricet #60 between 06/14/2013 and 09/05/2013 is not medically necessary or appropriate.

Diclofenac: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 60,67-6.

Decision rationale: The requested prescription for diclofenac between 06/14/2013 and 09/05/2013 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the employee has ongoing low back pain complaints. The MTUS guidelines recommend medications in the management of chronic pain be supported by

an assessment of pain relief and increased functional benefit. The clinical documentation submitted for review does not provide any evidence of increased functional benefit or pain relief as it is related to this medication. As such, the requested diclofenac between 06/14/2013 and 09/05/2013 is not medically necessary or appropriate.

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 (ODG); 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, Zolpidem (Ambien).

Decision rationale: The requested Ambien between 06/14/2013 and 09/05/2013 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the employee has been on this medication for an extended duration of time. Official Disability Guidelines recommend the use of Ambien for short courses of treatment of insomnia. The clinical documentation submitted for review does not provide any evidence that the employee has any functional benefit or relief of insomnia related symptoms as a result of this medication. Therefore, the requested Ambien between 06/14/2013 and 09/05/2013 is not medically necessary or appropriate.

Valium: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 25.

Decision rationale: The requested Valium between 06/14/2013 and 09/05/2013 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the employee has been on this medication for an extended duration of time. The MTUS guidelines recommend this medication for short courses of treatment. Long-term use is not recommended. Additionally, the clinical documentation submitted for review does not provide any evidence that the employee receives any functional benefit as it is related to this medication. As such, the requested Valium between 06/14/2013 and 09/05/2013 is not medically necessary or appropriate.

Home exercise kit: 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); Knee and Leg Chapter, Durable Medical Equipment.

Decision rationale: The requested home exercise kit between 06/14/2013 and 09/05/2013 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the employee has chronic low back pain. However, the clinical documentation submitted for review does not provide any evidence that the employee is currently participating in a home exercise program that would be supported by a home exercise kit. Additionally, Official Disability Guidelines recommend the use of durable medical equipment that is not beneficial to the patient in the absence of injury or illness. The requested exercise equipment would be considered useful to the employee in the absence of injury or illness. It is also not clearly indicated within the submitted documentation how this exercise equipment would serve a medical purpose as the employee is not participating in a home exercise program. As such, the requested 1 home exercise kit between 06/14/2013 and 09/05/2013 is not medically necessary or appropriate.

Fioricet #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Barbiturate-containing analgesic agents Page(s): 23.

Decision rationale: The requested Fioricet #60 between 06/14/2013 and 09/05/2013 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the employee has ongoing lumbar spine complaints. The MTUS guidelines do not recommend the use of barbiturate containing analgesic agents in the management of chronic pain due to a high risk of drug dependence. Additionally, the clinical documentation submitted for review does not provide any functional benefit or assessments of aberrant behavior or symptom response to the requested medication. As such, the requested Fioricet #60 between 06/14/2013 and 09/05/2013 is not medically necessary or appropriate.