

Case Number:	CM13-0017858		
Date Assigned:	12/27/2013	Date of Injury:	05/15/1987
Decision Date:	03/05/2014	UR Denial Date:	08/13/2013
Priority:	Standard	Application Received:	08/28/2013

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 Oklahoma and 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 57-year-old female who reported an injury on 05/15/1987. While assisting a patient, the patient reportedly injured her low back. This ultimately resulted in lumbar fusion. Prior treatments included medications, physical therapy, epidural steroid injections and a TENS unit. The patient developed chronic pain that was managed with medications to include Ambien 5 mg, Kadian extended release 50 mg, Norco 10/325 mg, Zanaflex 4 mg, and lorazepam 1 mg. The patient's medication usage was regularly monitored with urine drug screens. The patient's most recent clinical examination subjectively identified that the patient's activity level had remained the same and medications were "working well." Physical findings included tenderness to palpation along the paraspinal musculature in the lumbar region and limited range of motion secondary to pain. The patient's diagnoses included lumbar radiculopathy, low back pain, lumbar postlaminectomy syndrome and degenerative disc disease of the lumbar spine. The patient's treatment plan included continuation of medications and participation in a home exercise program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Ongoing Management Page(s): 78.

Decision rationale: The requested Norco 10/325 mg is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends that continuation of medications be based on a quantitative assessment of pain, specific increases in functionality, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does provide evidence that the patient is monitored for aberrant behavior and the patient's side effects are managed. However, the clinical documentation does not provide any evidence of a quantitative assessment of the patient's pain to determine the efficacy of the requested medications. Additionally, there was no specific documentation of increased functionality related to the medication usage. As such, the requested Norco 10/325 mg #120 is not medically necessary or appropriate.

Ambien 5mg #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)

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

Decision rationale: The requested Ambien 5 mg is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient has been on this medication for an extended duration of time. Official Disability Guidelines do not recommend this medication in the treatment of insomnia related to chronic pain for extended periods of time. Additionally, the clinical documentation does not provide an adequate assessment of the patient's sleep hygiene to support extending treatment beyond guideline recommendations. As such, the requested Ambien 5 mg is not medically necessary or appropriate.

Kadian ER 50mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Ongoing Management Page(s): 78.

Decision rationale: The requested Kadian ER 50 mg is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends that continuation of medications be based on a quantitative assessment of pain, specific increases in functionality, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does provide evidence that the patient is monitored for aberrant behavior and the patient's side effects are managed. However, the clinical documentation does not provide any evidence of a quantitative assessment of the patient's pain to determine the efficacy of the requested medications. Additionally, there was no specific

documentation of increased functionality related to the medication usage. As such, the requested Kadian ER 50 mg is not medically necessary or appropriate.