

<b>Case Number:</b>	CM13-0020296		
<b>Date Assigned:</b>	11/20/2013	<b>Date of Injury:</b>	04/20/2002
<b>Decision Date:</b>	01/28/2014	<b>UR Denial Date:</b>	08/21/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/05/2013

### 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 Orthopedic Surgery and is licensed to practice in New Hampshire, New York and Washington. 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 43-year-old male with a date of injury of 4/20/2002. The patient is being treated for chronic low back pain (LBP) and leg pain. Physical exam shows decreased range of motion (ROM) of the lumbar spine with tenderness and positive straight leg raising bilaterally. No motor or sensory deficits are documented in the legs. The patient had previous laminectomy surgery. The patient has been diagnosed with post laminectomy pain, degenerative disc disease (DDD), depression and anxiety. Prior treatment includes medications both opioid and nonopioid and surgery.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 MRI scan of the lumbar spine without contrast: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**Decision rationale:** There is no medical need for an MRI in this patient. There are no red flag indications for lumbar MRI. There is no neurologic deficit, fracture, or concern for tumor. The patient had axial back pain without neurologic deficit and has had previous surgery. There is also

no documentation of a recent trial of conservative measures to include physical therapy. Established criteria for MRI imaging of the spine are not met.

**prescription of Ambien CR 12.8mg: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Chronic Pain Chapter-Zolpidem (Ambien®)

**Decision rationale:** ODG Guidelines indicate that Ambien is recommended for short-term relief (2-6 weeks) of signs and symptoms associated with insomnia. The records indicate that the patient has been using Ambien since June 2012. Guidelines do not support long-term use. Also, the medical records do not document complaints of difficulty sleeping.

**Oxycontin 40mg #90: 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): 92.

**Decision rationale:** MTUS Guidelines support short-term use of opioids for severe pain control. They should be used for the shortest duration at the lowest possible dosages. Long-term use may be appropriate if the patient is showing evidence of improvement with pain and there is no evidence of noncompliant behavior. The medical records indicate that this patient has been using oxycontin on a long-term basis without evidence of functional improvement or reduction in pain. Guidelines for Oxycontin use are not met. Functional improvement not documented.

**Percocet 10/325mg up to #202: 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): 92.

**Decision rationale:** The patient has been taking percocet since June 2012. MTUS recommends short-term use of Percocet, which is a short acting opioid. Guidelines do not support the long-term use, as the efficacy remains unclear. Ongoing use of Percocet may be appropriate if there is continued functional improvement and pain relief along with the absence of noncompliance. Functional improvement is not documented in this patient's chart. Therefore, ongoing Percocet use is not medically necessary based on established criteria.

