

Case Number:	CM13-0024618		
Date Assigned:	12/18/2013	Date of Injury:	12/11/2001
Decision Date:	02/03/2014	UR Denial Date:	08/30/2013
Priority:	Standard	Application Received:	09/16/2013

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 Family Practice 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 35-year-old male who reported an injury on 12/11/2001. The patient developed chronic low back pain and bilateral knee pain managed by medications, a home exercise program and massage therapy. The patient's medications included Iodine 300 mg, Protonix 40 mg, Docusate 100 mg, Annulose 10 gm/15 ml, Ambien 10 mg, Flexeril 10 mg, hydrocodone/APAP 10/325 mg, Opana ER 10 mg, and Opana ER 5 mg. The patient was monitored for aberrant behavior by urine drug screens. The patient's most recent clinical examination findings included pain rated at 9/10 with medication as prescribed. Objective findings revealed no signs of intoxication or withdrawal, restricted lumbar range of motion with palpable tenderness and spasming along the paravertebral musculature. The patient's diagnoses included lumbosacral disc degeneration, hip pain, chronic back pain, knee pain, and sacroiliitis. The patient's treatment plan included continuation of a home exercise program and continuation of medication usage.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/Apap 10/325mg # 120: Upheld

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

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

Decision rationale: The requested hydrocodone/APAP 10/325 mg #120 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration and is monitored for aberrant behavior with urine drug screens that are regularly consistent. California Medical Treatment Utilization Schedule recommends that ongoing opioid usage in the management of a patient's chronic pain be supported by quantitative assessment of symptom relief, managed side effects, documentation of functional benefit, and monitoring for aberrant behavior. The clinical documentation submitted for review does not provide any evidence that the patient has increased functional benefit as the patient's sleeping hygiene has decreased and his activity level has decreased. Additionally, the patient's pain scale is rated at 9/10. As the documentation submitted for review does not provide evidence of increased functional capabilities or pain relief, continuation of the requested medication would not be indicated. As such, the requested hydrocodone/APAP 10/325 mg #120 is not medically necessary or appropriate.

Flexeril 10mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and, Cyclobenzaprine (Flexeril®) Page(s): 60 and 41.

Decision rationale: The requested Flexeril 10 mg #30 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration. California Medical Treatment Utilization Schedule does not support the extended use of muscle relaxants. Additionally, the patient has tenderness to palpation and muscle spasming upon palpation during the most recent clinical examination. Therefore, functional benefit of this medication is not supported. As the patient has been on this medication for an extended duration and there is no functional benefit noted within the documentation, continuation of Flexeril would not be indicated. As such, the requested Flexeril 10 mg #30 is not medically necessary or appropriate.

Ambien 10 mg #20: 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) Pain Chapter, Zolpidem.

Decision rationale: The requested Ambien 10 mg #20 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration. Official Disability Guidelines do not recommend the extended use of Zolpidem or Ambien. Additionally, the clinical documentation submitted for

review does not provide evidence of significant functional benefit related to this medication. It is noted within the documentation that the patient consistently has poor sleep hygiene and difficulty falling asleep and staying asleep. Therefore, continued use of this medication would not be indicated. As such, the requested Ambien 10 mg #20 is not medically necessary or appropriate.