MAXIMUS Federal Services

Case Number:	CM13-0029051		
Date Assigned:	02/26/2014	Date of Injury:	02/22/1996
Decision Date:	08/01/2014	UR Denial Date:	08/20/2013
Priority:	Standard	Application Received:	09/23/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert 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 expert 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 injured worker is a 58-year-old female who reported an injury on 02/22/1996. The mechanism of injury was not provided for clinical review. The diagnoses were not provided for clinical review. Previous treatment included medication and psychological evaluation. Within the psychological assessment review dated 08/13/2013, the injured worker completed a Beck Depression Inventory psychological screening. The clinical documentation submitted noted based on the findings of the screening, the injured worker's history, and physician examination findings, it had been determined that the patient does not require immediate additional psychiatric intervention. The request submitted is for Ambien, oxycodone, and OxyContin. However, a rationale was not provided for clinical review. The Request for Authorization was not submitted in the clinical documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10MG #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain, Zolpidem.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain, Zolpidem.

Decision rationale: The request for Ambien 10 mg #30 is not medically necessary. The injured worker underwent a Beck Depression Inventory assessment on 08/12/2013. The Official Disability Guidelines note zolpidem is a prescription, short-acting nonbenzodiazepine hypnotic, which was approved for short-term, usually 2 to 6 weeks, treatment of insomnia. The guidelines note proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. All sleeping pills, so-called minor tranquilizers, and anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for longterm use. They can be habit-forming and may impair function and memory more than opioid pain relievers. There is also a concern that they may increase pain and depression over longterm. Cognitive behavioral therapy should be an important part of insomnia treatment plan. There is a lack of significant objective findings indicating the injured worker is treated for diagnosed with insomnia. The injured worker had been utilizing the medication for an extended period of time since at least 08/2013, which exceeds the guideline recommendations of short-term use of 2 to 6 weeks. The request submitted failed to provide the frequency of the medication. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. Therefore, the request is not medically necessary.

Oxycodone HCL 5MG #300: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

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

Decision rationale: The request for oxycodone HCL 5 mg #300 is not medically necessary. The injured worker underwent a Beck Depression Inventory assessment on 08/12/2013. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. The provider did not document an adequate and complete pain assessment within the documentation. There is a lack of documentation indicating the medication had been providing objective functional improvement. Additionally, the use of a urine drug screen had not been provided for clinical review. The injured worker had been utilizing the medication since at least 08/2013. The request as submitted failed to provide the frequency of the medication. The provider's rational for the request was not provided. Therefore, the request for oxycodone HCL 5 mg #300 is not medically necessary.

Oxycontin 40MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

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

Decision rationale: The request for Oxycontin 40 mg #90 is not medically necessary. The injured worker underwent a Beck Depression Inventory psychological assessment on 08/12/2013. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. The provider did not document an adequate and complete pain assessment within the documentation. There is a lack of documentation indicating the medication had been providing objective functional benefit and improvement. The request as submitted failed to provide the frequency of the medication. Additionally, the use of a urine drug screen was not provided for clinical review. The injured worker had been utilizing the medication since at least 08/2013. Therefore, the request for OxyContin 40 mg #90 is not medically necessary.