

Case Number:	CM13-0050551		
Date Assigned:	12/27/2013	Date of Injury:	02/09/2010
Decision Date:	06/25/2014	UR Denial Date:	11/05/2013
Priority:	Standard	Application Received:	11/13/2013

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 Internal Medicine and is licensed to practice in Arizona. 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 47year old man with a medical history of diabetes, hypertension and asthma who sustained a work-related injury on 2/9/10 resulting in chronic low back pain and leg pain. His diagnoses include post laminectomy syndrome, left sided lower extremity radiculopathy/radiculitis and lumbar disc displacement s/p anterior-posterior L5-S1 fusion and decompression. The medical record is reviewed including the visits with the primary spine doctor dated 1/2/14, 10/31/13 and 9/5/13. Prior treatments include oral analgesic medication including narcotic medication and non-narcotic medication, physical therapy, acupuncture, epidural injections, spinal surgery x2 with anterior and posterior lumbar fusion. On 10/31/13 the primary surgical provider noted the injured worker continued to have pain in the low back rated 7-8/10, constant and radiating to the left leg with numbness and weakness. The physical exam noted a normal gait, tenderness to palpation of the L4-5 and L5-S1, decreased range of motion with strength of the left leg 3-4/5 of the left leg with sensation and DTR intact. The treatment included prescription of Ambien 10mg #30 with 3 refills and Norco 10/325mg #120 with 3 refills. The utilization review declined the use of Ambien as not medically necessary on 11/5/13. The use of Norco was modified with fewer tablets for taper and discontinuation due to it not being medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO 10/325MG #120 WITH 3 REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: The injured worker is being treated for chronic back pain and neuropathic pain. Norco 10/325mg is a combination medication including Hydrocodone and Acetamenophen. It is a short-acting, pure opiod agonist used for intermittent or breakthrough pain. According to the California MTUS section of chronic pain regarding short-acting opiods, they should be used to improve pain and functioning. There are no trials of long-term use in patients with neuropathic pain and the long term efficacy when used for chronic back pain is unclear. Adverse effects of opiods include drug dependence. Management of patients using opiods for chronic pain control includes ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. In this case the documentation does not support that the use of Norco is decreasing the pain significantly or improving function. The continued use of Norco is not medically necessary.

AMBIEN 10MG #30 WITH 3 REFILLS: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Uptodate.com- Treatment of Insomnia

Decision rationale: The California MTUS is silent regarding the use of Ambien for chronic insomnia. The FDA has approved the use of Ambien for short-term treatment of insomnia (with difficulty of sleep onset). Ambien is not approved for the long-term treatment of insomnia. When treating insomnia all patients should receive therapy for any medical condition, psychiatric illness, substance abuse or sleep disorder that may be precipitating or exacerbating the insomnia. For patients who continue to have insomnia that is severe enough to require intervention cognitive behavioral therapy (CBT) is the initial therapy that is recommended. If a patient requires a combination of behavioral therapy and medication a short acting medication is recommended for 6-8 weeks and then tapered. If the patient is still having symptoms they may require evaluation in a sleep disorder center prior to the institution of long-term medications. In this case the documentation does not support that the patient is having significant sleep disruption or that he has been evaluated for medical or psychiatric illness that may be precipitating or exacerbating the insomnia. The use of Ambien is not medically necessary.