

Case Number:	CM13-0050908		
Date Assigned:	12/27/2013	Date of Injury:	07/15/2002
Decision Date:	03/10/2014	UR Denial Date:	10/18/2013
Priority:	Standard	Application Received:	11/13/2013

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 Internal Medicine, has a subspecialty in Pulmonary Disease, 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 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 48-year-old male who reported an injury on 07/15/2002. The patient is currently diagnosed with chronic intractable pain, degenerative disc disease in the lumbar spine with radiculopathy, spondylolisthesis, insomnia, and anxiety. The patient was seen by the provider on 11/04/2013. The patient reported intermittent lower back pain without radiation and ongoing shoulder pain. Physical examination revealed tenderness to palpation across the trapezii bilaterally, tenderness in the midline lumbar spine, mild paraspinous muscle tension, positive straight leg raising bilaterally, and positive LasA"gue's sign bilaterally. Treatment recommendations included continuation of current medication including oxycodone, alprazolam, Ambien, Cialis, Nexium, and gabapentin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone IR 30mg, #360 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Baseline pain and functional assessment should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report chronic pain. The patient's physical examination continues to reveal tenderness to palpation in multiple areas as well as positive straight leg raising and LasA`gue's testing. Additionally, it was noted by [REDACTED] on 07/19/2013, the patient was to begin tapering of oxycodone. As satisfactory response to treatment has not been indicated, the request is non-certified.

Alprazolam 0.5mg, #60 with one refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

Decision rationale: The California MTUS Guidelines state benzodiazepines are not recommended for long-term use, because long-term efficacy is unproven and there is a risk of dependence. As per the documentation submitted for review, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report psychiatric symptoms. The California MTUS Guidelines do not recommend chronic use of benzodiazepines, for longer than 4 weeks. Based on the clinical documentation submitted and the California MTUS Guidelines, the request is non-certified.

Ambien 10mg, #30 with one refill: 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 Official Disability Guidelines (ODG), Chronic Pain Chapter, Insomnia Treatment.

Decision rationale: The Official Disability Guidelines (ODG) state insomnia treatment is recommended based on etiology. Ambien is indicated for short-term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. As per the documentation submitted for review, the patient has continuously utilized this medication. There is no documentation of a functional improvement. The patient reported no change in activities of daily living, physical and social activities, or sleep quality. As guidelines do not recommend long-term use of this medication, the current is not medically appropriate. Therefore, the request is non-certified.

Nexium 20mg, #60 with 5 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: The California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor. As per the documentation submitted for review, the patient has continuously utilized this medication. However, there is no evidence of gastrointestinal complaints. There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the patient does not meet criteria for the use of a proton pump inhibitor. As such, the request is non-certified.