

Case Number:	CM13-0051347		
Date Assigned:	12/27/2013	Date of Injury:	08/14/2004
Decision Date:	06/23/2014	UR Denial Date:	11/08/2013
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 Occupational Medicine, 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 applicant is a represented [REDACTED] employee who has filed a claim for chronic mid and low back pain associated with an industrial injury sustained on August 14, 2004. Thus far, the applicant has been treated with analgesic medications, transfer of care to and from various providers in various specialties, prior spine surgery, and an intrathecal pain pump. A clinical progress note dated October 29, 2013 states that the applicant reports constant pain (9/10 on a good day and 10/10 on a bad day). The applicant's pain interferes with her ability to sleep, perform activities of daily living, and function emotionally. The applicant is having difficulty bending and even eating meals. She is presently on desipramine, Oxycodone, Ativan, Fioricet, Lidoderm patches, intrathecal Dilaudid, intrathecal baclofen, intrathecal bupivacaine, topical compound, Zoloft, prednisone, Ambien, Prilosec, Levoxyl, calcium, vitamin D, and a topical EMLA cream. Upper and lower extremity strength ranges from 4+/5 to 5/5. Allodynia is appreciated about the legs. Multiple medications are refilled, including intrathecal agents such as Dilaudid, Clonidine, baclofen, and bupivacaine. The applicant is asked to pursue epidural steroid injection therapy. The applicant's work status is not detailed on this date in the clinical summary.

IMR ISSUES, DECISIONS AND RATIONALES

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

CLONIDINE 50MCG/DAY: 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 MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ,

Decision rationale: While page 55 of the MTUS Chronic Pain Medical Treatment Guidelines does support the addition of Clonidine as a second-state agent to an intrathecal drug delivery system, in this case, the applicant has been using intrathecal Clonidine for some time. The applicant has failed to exhibit appropriate analgesia or improved performance of activities of daily living as a result of this medication. The applicant is unable to perform even basic activities of daily living, such as lifting a fork without pain. The applicant's pain levels range from 9/10 to 10/10, seemingly with or without medications. The applicant remains highly reliant on various other forms of medical treatment, including oral opioid agents, anxiolytic agents, antidepressants, topical agents, etc. The applicant is also pursuing a thoracic epidural steroid injection. All the above, taken together, imply that introduction of intrathecal Clonidine has not been effective in alleviating the applicant's pain or in improving the applicant's function. As such, the request is not medically necessary.

240 ROXICODONE 15MG: 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 MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ,

Decision rationale: As noted on page 80 of the MTUS Chronic Pain Medical Treatment Guidelines, the cardinal criteria for continuation of opioid therapy include evidence of successful return to work, improved function, and/or reduced pain achieved as a result of ongoing opioid therapy. In this case, these criteria have not been met. The applicant is seemingly off of work. The applicant has failed to achieve the requisite analgesia and/or improved performance of activities of daily living as a result of ongoing opioid (and non-opioid) therapy. As such, the request is not medically necessary.

90 ATIVAN 1MG: 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 MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ,

Decision rationale: As noted on page 24 of the MTUS Chronic Pain Medical Treatment Guidelines, benzodiazepines such as Ativan are not recommended for chronic or long-term use

purposes, for anxiolytic effect, antidepressant effect, or anticonvulsant effect; the attending provider has not proffered any applicant-specific rationale, narrative, or commentary so as to support chronic, ongoing usage of Ativan so as to try and counter the unfavorable MTUS recommendation. It does not appear, moreover, that the applicant has responded favorably to ongoing usage of the same. As such, the request is not medically necessary.

AMBIEN 5MG #30 WITH TWO REFILLS: 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 MTUS: OFFICIAL DISABILITY GUIDELINES , CHRONIC PAIN CHAPTER, ZOLPIDEM TOPIC,

Decision rationale: The MTUS/ACOEM guidelines do not specifically address the topic, so the Official Disability Guidelines (ODG) were used instead. As noted in the ODG, zolpidem or Ambien is indicated in the short-term treatment of insomnia, typically on the order of two to six weeks. It is not indicated for chronic, long-term, and/or scheduled use purposes for which it is being proposed here. AS such, the request is not medically necessary.