

Case Number:	CM13-0051811		
Date Assigned:	12/27/2013	Date of Injury:	02/14/2009
Decision Date:	03/11/2014	UR Denial Date:	11/10/2013
Priority:	Standard	Application Received:	11/14/2013

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 Physical Medicine and Rehabilitation 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 02/14/2009. The mechanism of injury was lifting. This injury resulted in low back pain that radiated to the bilateral lower extremities. He has received several conservative treatments to date, to include medications, activity modifications, rest, multiple injections, a home exercise program, and sleep aids. The patient's chronic pain is being managed by a chronic pain physician, and his medications are adjusted as needed. A current list of his medications includes Lexapro 10 mg, 1 tablet daily; Norco 10/325 mg, 1 tablet 4 times a day as needed; and Ambien 10 mg, 1 tablet at night. At his most recent clinical visit dated 11/04/2013, he was also prescribed Percocet for severe pain, not to be taken while utilizing Norco, and Flexeril for muscle spasms due to his recent exacerbation of symptoms. There was no other clinical information submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

60 Cyclobenzaprine 10mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Muscle Relaxants Page(s): 63-64.

Decision rationale: The California MTUS/ACOEM Guidelines recommend the use of non-sedating muscle relaxants as a second-line option for the short-term treatment of acute exacerbations in patients with chronic low back pain. Cyclobenzaprine in particular, should not be utilized in excess of 3 weeks. The clinical information submitted for review failed to provide evidence that a first-line treatment option had been implemented and failed, i.e., ibuprofen. Furthermore, although the patient had subjective complaints of muscle spasm, the physical examination did not find objective evidence of their presence. Without evidence of a first-line therapy having been tried and failed, as well as no presence of muscle spasms upon physical examination, the medical necessity of this request has not been established. As such, the request for 60 cyclobenzaprine 10 mg is non-certified.

21 Percocet 7.5/325mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Opioids Page(s): 74-95.

Decision rationale: The California MTUS/ACOEM Guidelines recommend the use of opioids to treat moderate to severe pain. The most recent clinical note submitted for review dated 11/04/2013, revealed that the prescription for Percocet was new and was being prescribed for the patient's episodes of severe pain. The California MTUS Guidelines state that before initiating a new opioid, baseline pain and functional assessments should be made. This should include physical, daily and work activities, and should be measured by using a validated instrument or numerical rating scale to allow for future comparison to determine medication efficacy. The clinical information submitted for review did not provide any evidence that objective functional measurements had been obtained; there were no range of motion values, no discussion regarding tolerance of daily or work activities, and there were no pain levels obtained. Without objective information with which to compare future measurements, medication efficacy cannot be determined. As such, the guideline recommendations have not been met, and the request for 21 Percocet 7.5/325 mg is non-certified. Although this was a new prescription, if the patient had begun utilizing this medication, it is expected that the physician would allow for safe weaning.

30 Ambien 10mg: 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, Pain, Zolpidem (Ambien)).

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

Decision rationale: The California MTUS/ACOEM Guidelines do not specifically address the use of Ambien. Therefore, the Official Disability Guidelines were supplemented. The ODG

states that Ambien may be used for the short-term (usually 2 to 6 weeks) treatment of insomnia. The clinical information submitted for review provided evidence that the patient has been utilizing Ambien since at least 05/2013; however, there was no discussion regarding the medication's efficacy. Furthermore, this length of use clearly exceeds guideline recommendations of no more than 6 weeks; and therefore, it is recommended that the patient be weaned from this medication at this time. As such, the request for 30 Ambien 10 mg is non-certified.