

Case Number:	CM13-0069313		
Date Assigned:	01/03/2014	Date of Injury:	05/02/2004
Decision Date:	07/15/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	12/20/2013

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 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 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 43 year old female who reported an injury on 01/10/2006. The mechanism of injury was not stated. Current diagnoses include backache, lumbar spondylosis, and lumbar facet syndrome. The injured worker was evaluated on 11/01/2013. The injured worker reported lower back pain as well as bilateral hip pain. Current medications include Senokot S, OxyContin 10 mg, and Norco 10/325 mg. Physical examination revealed an antalgic gait, restricted lumbar range of motion, tenderness to palpation, tight muscle banding, positive Fabere's testing, positive facet loading maneuver, positive pelvic compression testing, tenderness over the bilateral SI joints, trigger points with radiating pain and a twitch response, tenderness over the greater trochanter bilaterally, diminished strength in the lower extremities, and patchy sensation to light touch. Treatment recommendations at that time included continuation of current medication.

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 MedScape 2009 and PDR 2009.

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 state insomnia treatment is recommended based on etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report poor sleep quality. There is no documentation of a failure to respond to non-pharmacologic treatment prior to the initiation of a prescription product. Based on the clinical information received, the request is not medically necessary and appropriate.

Senokot S #120: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation nlm.nih.gov website.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 77. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Opioid Induced Constipation Treatment.

Decision rationale: The MTUS Chronic Pain Guidelines state prophylactic treatment of constipation should be initiated when also initiating opioid therapy. The Official Disability Guidelines state opioid induced constipation treatment is recommended. First line treatment includes increasing physical activity, maintaining appropriate hydration, and advising the patient to follow a proper diet. As per the documentation submitted, the injured worker does not maintain a diagnosis of chronic constipation. The injured worker has utilized this medication since 12/2012. There is no evidence of a failure to respond to first line treatment as recommended by the Official Disability Guidelines. There is also no frequency listed in the current request. As such, the request is not medically necessary and appropriate.

OxyContin 10mg #60: 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 MTUS Chronic Pain Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has utilized OxyContin 10 mg since 03/2013. There is no evidence of objective functional improvement. There is also no frequency listed in the current request. Therefore, the request is not medically necessary and appropriate.

Norco 10/325mg #90 with 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The MTUS Chronic Pain Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has utilized Norco 10/325 mg since 12/2012. There is no documentation of objective functional improvement. There is also no frequency listed in the current request. As such, the request is not medically necessary and appropriate.