

Case Number:	CM13-0070280		
Date Assigned:	01/03/2014	Date of Injury:	09/26/2007
Decision Date:	06/16/2014	UR Denial Date:	12/03/2013
Priority:	Standard	Application Received:	12/24/2013

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 & Rehabilitation, 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 injured worker is a 41-year-old male who reported an injury on 09/26/2007. The mechanism of injury was not stated. Current diagnoses include cervical spine disc syndrome, lumbar spine disc syndrome, low back syndrome, depression, insomnia, and headaches. The injured worker was evaluated on 11/04/2013. The injured worker reported 8/10 pain with numbness and weakness. Physical examination on that date revealed diminished grip strength, limited cervical range of motion with spasm, limited lumbar range of motion with spasm, positive Minor's testing, positive Valsalva and Kemp's testing, positive straight leg raising on the left, and diminished strength in the bilateral lower extremities. Previous conservative treatment includes an epidural steroid injection and medication management. It is also noted that the injured worker underwent a lumbar spine fusion with decompression and discectomy on an unknown date, as well as a microdiscectomy in 1999. Treatment recommendations at that time included a refill of Norco, Ambien, and Lidoderm, as well as an internal medicine consultation, a pain management consultation, a neurological consultation, a psychiatric consultation, and a urine toxicology test.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 PRESCRIPTION FOR NORCO 10/325 MG: Upheld

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

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

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid 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 04/2013 without any evidence of objective functional improvement. There is also no frequency or quantity listed in the current request. As such, the request is not medically necessary.

PRESCRIPTION FOR AMBIEN 10 MG #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain.

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: 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 days to 10 days. The injured worker does maintain a diagnosis of insomnia. However, the injured worker has utilized Ambien 10 mg since 04/2013 without evidence of objective functional improvement. There is no mention of a failure to respond to non-pharmacologic treatment prior to the initiation of a prescription product. There is also no frequency listed in the current request. As such, the request is not medically necessary.

1 NEUROLOGICAL CONSULTATION AND EXAMINATION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 166,289.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: California MTUS/ACOEM Practice Guidelines state referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or an agreement to a treatment plan. It is noted, the injured worker has been seen by a neurologist. The current request is for a second neurological consultation. The medical necessity for a second opinion has not been established. As such, the request is not medically necessary.

1 URINE TOXICOLOGY TEST: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43,77,89.

Decision rationale: California MTUS Guidelines state drug testing is recommended as an option, using a urine drug screen to assess for the use or presence of illegal drugs. Official Disability Guidelines state the frequency of urine drug testing should be based on documented evidence of risk stratification. There is no evidence of noncompliance or misuse of medication. There is also no indication that this injured worker falls under a high risk category that would require frequent monitoring. Therefore, the medical necessity for repeat testing has not been established. As such, the request is not medically necessary.