

Case Number:	CM13-0071069		
Date Assigned:	01/08/2014	Date of Injury:	01/12/2012
Decision Date:	06/12/2014	UR Denial Date:	12/11/2013
Priority:	Standard	Application Received:	12/26/2013

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 52-year-old female who reported an injury on 01/12/2012. The mechanism of injury was not provided for review. The injured worker's treatment history included surgical intervention, a home exercise program, physical therapy, medications, injections, and assisted ambulation with a cane. The injured worker was evaluated on 10/08/2013. The injured worker's medications included Norco 10/325 mg, Robaxin, and Sonata. Physical findings included restricted range of motion secondary to pain with tenderness to palpation of the lumbar spine and a positive right-sided straight leg raising test. The injured workers' diagnoses included a lumbosacral sprain/strain with radiculitis, a lateral sacroiliac joint sprain, and right knee sprain/strain. The injured worker's treatment plan included referral to Pain Management, continuation of a home exercise program, and a TENS unit and a refill of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

HYDROCODONE/APAP 10/325MG QUANTITY 120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-Going Management Page(s): 78.

Decision rationale: The requested #120 hydrocodone/APAP 10/325 mg is not medically necessary or appropriate. C Chronic Pain Medical Medical Treatment Guidelines recommends the continued use of opioids be supported by documented functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence of the injured worker being monitored of aberrant behavior. The clinical documentation submitted for review does not provide any evidence of the injured worker having any functional benefit or pain relief resulting from medication usage. Additionally, there is no documentation that the injured worker is regularly assessed for aberrant behavior. The clinical documentation indicates that the injured worker has been on this medication for an extended duration of time. Therefore, ongoing documentation would need to be provided to support continued use. Additionally, the request as it is submitted does not provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request for 120 Hydrocodone/APAP 10/325 mg is not medically necessary and appropriate.

ZALEPLON 10MG # 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.

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

Decision rationale: The requested #30 Zaleplon 10 mg is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this medication. Official Disability Guidelines recommend pharmacological intervention for insomnia related to chronic pain when injured workers have failed to respond to nonpharmacological interventions. Additionally, the clinical documentation does indicate that the injured worker has been on this medication since at least 08/2013. An adequate assessment of the injured worker's sleep patterns that would require pharmacological intervention are not provided within the documentation. There is no documentation that the injured worker has failed to respond to nonpharmacological treatments. As such, the requested #30 Zaleplon 10 mg is not medically necessary and appropriate.