

Case Number:	CM13-0071927		
Date Assigned:	01/08/2014	Date of Injury:	01/08/1990
Decision Date:	04/30/2014	UR Denial Date:	12/05/2013
Priority:	Standard	Application Received:	12/30/2013

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 patient is a 52-year-old male who reported an injury on 01/08/1990. The mechanism of injury was not stated. The patient is currently diagnosed with post lumbar laminectomy syndrome, lumbar radiculopathy, lumbar facet syndrome, and shoulder pain. The patient was seen on 11/18/2013. The patient reported persistent lower back and right shoulder pain. Physical examination on that date revealed restricted lumbar range of motion, tenderness to palpation with spasm, positive facet loading maneuver, positive straight leg raising, diminished reflexes, limited range of motion of the right shoulder, positive Hawkins and Neer testing, positive empty can and Speed testing, positive drop arm testing, and tenderness in the acromioclavicular joint and sub deltoid bursa. Treatment recommendations at that time included continuation of Ambien, Oxycodone, Viagra, and Naprosyn.

IMR ISSUES, DECISIONS AND RATIONALES

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

OXYCODONE 15 MG 1 TAB QID PRN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 92.

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 patient has utilized Oxycodone 15 mg tablets since 08/2013. There is no evidence of a satisfactory response to treatment, as indicated by a decrease in pain level, increase in function, or improved quality of life. There is also no quantity listed in the current request. Therefore, the request is not medically appropriate. As such, the request is non-certified.

AMBIEN 10 MG 1 TAB QHS PRN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines and Insomnia Treatment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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 to 10 days. The patient has utilized Ambien 10 mg since at least 08/2013. Despite ongoing treatment, there is no evidence of objective improvement. There is also no quantity listed in the current request. Therefore, the request is not medically appropriate. As such, the request is non-certified.

NAPROSYN 500 MG 1 TAB BID PRN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of pain, NSAIDs are recommended as a second line treatment after acetaminophen. The patient has utilized Naprosyn 500 mg since at least 08/2013. There is no evidence of objective functional improvement. There is also no quantity listed in the current request. Therefore, the request is not medically appropriate. As such, the request is non-certified.

VIAGRA 100: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmed>

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: www.nlm.nih.gov

Decision rationale: Viagra is used to treat erectile dysfunction. Although it is noted that the patient reports erectile dysfunction, the current request does not include a specific quantity. Therefore, the current request cannot be determined as medically appropriate. As such, the request is non-certified.