

Case Number:	CM14-0007252		
Date Assigned:	02/12/2014	Date of Injury:	09/20/2010
Decision Date:	07/11/2014	UR Denial Date:	12/27/2013
Priority:	Standard	Application Received:	01/20/2014

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 Occupational Medicine, 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:

Medical records from 2013 through 2014 were reviewed. The latest progress report, dated February 13, 2014, showed persistent midline sternal pain, right rib pain, and bilateral thoracic back pain. It was exacerbated by any activities such as sitting and lying down; however, it was mitigated by standing. Physical examination revealed thoracic and lumbar ranges of motion were restricted by pain in all directions. There was tenderness of the left sternum and xiphoid process, right intercostals and right ribs, and bilateral thoracic paraspinal muscles overlying the T9-T12 facet joints. Thoracic extension was worse than flexion. Thoracic and lumbar facet joint provocative maneuvers were positive. Nerve root tension signs were negative bilaterally. Muscle stretch reflexes were symmetric bilaterally in the lower extremities. Clonus, Babinski, and Hoffmann's signs were absent bilaterally. There was full muscle strength in bilateral lower extremities but decreased sensation along the T7, T8, and T9 dermatomes. Treatment to date has included fluoroscopically-guided bilateral T10-T11 and bilateral T11-T12 facet joint radiofrequency nerve ablation (neurotomy/rhizotomy) (May 18, 2012) and medications such as Norco since 2012 and Zolpidem since November 2013. Utilization review from December 27, 2013 denied the request for the purchase of Hydrocodone 10/325mg #120 because the documentation did not identify measurable analgesic benefit with the use of opioids and there was no documentation of functional benefit with ongoing use. The request for the purchase of Zolpidem 10mg #30 was denied because the documentation did not describe the failure of behavioral interventions related to sleep hygiene. There was no documented symptom of insomnia.

IMR ISSUES, DECISIONS AND RATIONALES

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

HYDROCODONE 10/325 MG, #120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 78-81.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, ongoing opioid treatment is not supported unless prescribed at the lowest possible dose and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In this case, the patient has been on Norco for at least 2012. A medical record, dated February 13, 2014, appealed for the reconsideration of Norco since it provided 40% improvement of the patient's pain. It likewise resulted to maintenance of his activities of daily living such as self-care, dressing and food preparation with consistent UDS (urine drug screen) results. The guideline criteria were met. The request for Hydrocodone 10/325 mg, 120 count, is medically necessary and appropriate.

ZOLPIDEM 10 MG, #30: Upheld

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

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, Zolpidem.

Decision rationale: The CA MTUS does not address this topic. According to the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines, (ODG), Pain Chapter, Zolpidem treatment was used instead. ODG states that zolpidem is a non-benzodiazepine hypnotic, which is approved for short-term (usually two to six weeks) treatment on insomnia. In this case, the patient has been taking Zolpidem since November 2013. This exceeds the guidelines recommendation of short-term use for up to six weeks. Moreover, the documentation did not indicate functional gains from the use of Zolpidem. Furthermore, there was no discussion concerning the patient's sleep hygiene. The request for Zolpidem 10 mg, thirty count, is not medically necessary or appropriate.