

Case Number:	CM14-0008368		
Date Assigned:	02/12/2014	Date of Injury:	10/23/2008
Decision Date:	09/18/2014	UR Denial Date:	12/19/2013
Priority:	Standard	Application Received:	01/21/2014

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 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 46-year-old male who reported an injury on 10/23/2008. The mechanism of injury was not provided. On 01/23/2014, the injured worker presented with back pain. Upon examination there was an antalgic gait. There was full muscle strength and normal tone and 2+ deep tendon reflexes in the bilateral patellae with intact sensation. There was a positive Faber maneuver bilaterally. There was pain to palpation over the L4-5 and L5-S1 hardware heads bilaterally with pain with rotational extension, indicative of facet capsular tears and secondary myofascial pain with triggering. There was minimal swelling to the left lower back just lateral to the well healed scar. The diagnoses were chronic low back pain and lumbar spondylosis. Prior therapy included medications, activity modification, therapeutic modalities and procedure care.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO 10/325 MG, #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 78.

Decision rationale: The California MTUS Guidelines recommend the use of opioids for ongoing management of chronic pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is lack of evidence of an objective assessment of the injured worker's pain level, functional status, evaluation of risks for aberrant drug abuse behavior and side effects. The injured worker has been prescribed Norco since at least 12/2013. The efficacy of the medication was not provided. Additionally, the provider's request does not indicate the frequency of the medication in the request as submitted. As such, Norco 10/325 mg, #120 is not medically necessary.

BUTRANS 20 MCG/HR PATCH, #4 WITH 2 REFILLS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation PHYSICIANS DESK REFERENCE.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine Page(s): 26.

Decision rationale: The California MTUS recommends Butrans for treatment of opiate addiction. It is also recommended as an option for chronic pain, especially after detoxification in injured workers who have a history of opiate addiction. There is lack of documentation in the medical documents reviewed that the injured worker is recommended for opiate addiction treatment. He has been prescribed Butrans since at least 12/2013. The efficacy of the medication was not provided. Additionally, the provider's request does not indicate the frequency of the medication in the request as submitted. As such, Butrans 20 mcg/hr Patch, #4 With 2 Refills is not medically necessary.

AMBIEN 10 MG, #60 WITH 3 REFILLS: Upheld

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

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

Decision rationale: The Official Disability Guidelines state Ambien is a prescription short acting nonbenzodiazepine hypnotic, which is approved for the short term, usually 2 to 6 weeks treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short term benefit. While sleeping pills and antianxiety agents are commonly prescribed in chronic pain, pain specialists rarely recommend them for long term use. They can be habit forming and they may impair function and memory more than opioid pain relievers. There is also a concern that they may increase pain and depression over the long term. Cognitive behavioral therapy should be an important part of an insomnia treatment plan. The provider's request for Ambien 10 mg with a quantity of 60 and 3 refills exceeds the guidelines recommendation of short term treatment. The efficacy of the prior use of Ambien has not been provided. Additionally, there was lack of signs and symptoms of

insomnia to include whether the injured worker is having trouble sleep initiation, maintenance or early awakening. As such, the request is not medically necessary.