

Case Number:	CM14-0012703		
Date Assigned:	02/21/2014	Date of Injury:	03/13/1994
Decision Date:	06/30/2014	UR Denial Date:	01/27/2014
Priority:	Standard	Application Received:	01/31/2014

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 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 74-year-old male with an injury reported on 03/13/1994. The mechanism of injury was not provided within the clinical notes. The clinical note dated 01/21/2014 reported that the injured worker complained of low back and bilateral hip pain. The physical examination revealed tenderness to the low lumbar paravertebral musculature. The injured worker's range of motion to the lumbar spine demonstrated forward flexion to 40 degrees, extension to 10 degrees, and lateral bend to 30 degrees. The injured worker's prescribed medication list was not provided in the recent clinical note. The injured worker's diagnoses included pseudoarthrosis to L2-3, multilevel lumbar decompression and fusion, status post removal of hardware from limitation of lumbar spine motion. The provider requested hydrocodone/acetaminophen and Zolpidem; the rationale was not provided. The request for authorization was submitted on 01/31/2014. The injured worker's prior treatments were not included in recent clinical note.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR 1 PRESCRIPTION HYDROCODONE/APAP 10/325MG, #60 BETWEEN 11/22/2013 AND 11/22/2013: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OPIOIDS, CRITERIA FOR USE,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list, page 91, and Opioids, criteria for use Page(s): 78.

Decision rationale: The retrospective request for 1 prescription hydrocodone/apap 10/325 mg, quantity 60 between 11/22/2013 and 11/22/2013 is non-certified. The injured worker complained of low back and bilateral hip pain. The injured worker's current prescribed medication regime was not provided in recent clinical note. The requesting provider's rationale for hydrocodone/APAP was not provided. The California MTUS guidelines hydrocodone/acetaminophen is a short-acting opioid, which is an effective method in controlling chronic, intermittent or breakthrough pain. The guidelines recognize four domains that have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. There is a lack of information provided documenting the efficacy of hydrocodone/APAP as evidenced by decreased pain and significant objective functional improvements. Furthermore, the requesting provider did not specify the utilization frequency of the medication being requested. Given the information provided, the request is not medically necessary.

RETROSPECTIVE REQUEST FOR 1 PRESCRIPTION FOR ZOLPIDEM TARTRATE 10MG #30 BETWEEN 11/22/2013 AND 11/22/2013: 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, Zolpidem (Ambien).

Decision rationale: The retrospective request for 1 prescription for zolpidem tartrate 10 mg quantity 30 between 11/22/2013 and 11/22/2013 is non-certified. The injured worker complained of low back and bilateral hip pain. The injured worker's current prescribed medication regime was not provided in recent clinical note. The requesting provider's rationale for Zolpidem was not provided. The Official Disability Guidelines recommend Zolpidem as a short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six 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. There is a lack of information provided documenting the efficacy of zolpidem as evidenced by increased sleep and significant objective functional improvements. There is a lack of clinical information indicating the injured worker had a diagnosis of insomnia. There was a lack of clinical evidence indicating the injured worker had difficulty sleeping, requiring a sleep aide. The clinical note dated 06/18/2013 indicated the injured worker had been using Zolpidem at that time. The guidelines approve zolpidem for short-term utilization only. The injured worker's utilization of zolpidem has exceeded the guideline recommendations. Furthermore, the requesting provider did not specify the utilization frequency of the medication being requested. Therefore, the request is not medically necessary.

