MAXIMUS Federal Services

Case Number:	CM14-0018488		
Date Assigned:	06/11/2014	Date of Injury:	08/19/2004
Decision Date:	08/18/2014	UR Denial Date:	01/17/2014
Priority:	Standard	Application Received:	02/13/2014

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 56-year-old male who reported an injury on 08/19/2004 who sustained an industrial injury to his lower bilateral lower back and lumbar spine. On 03/31/2011 the injured worker underwent an MRI of the lumbar spine that revealed post-surgical changes at L3-L4 and L5-S1 focal clumping of the nerve roots to the dorsal aspect of the theca sac at the level of L4-L5. It was noted that this may represent arachnoiditis. At L3-L4, 2.33mm there was disc protrusion and facet hypertrophy produced bilateral neuroforaminal narrowing. On 06/11/2014 the injured worker complained of low back pain rated at 9/10. It was noted the pain with medications was a 4/10 and without medications 10/10. The injured worker characterized his low back pain as aching, cramping, exhausting, gnawing, heavy, sharp, shooting, and tender and throbbing. It was noted the injured worker blow back and leg pain represents about 70% and 30 %, respectively. It was noted the pain caused the injured worker difficulties with daily living activities. The physical examination of the lumbar spine revealed range of motion extension and flexion was 50%, right rotation was 30%, and left rotation was 40% all limited. There was tight band, spasms, hyper tonicity all moderate. There was tenderness along the bilateral lumbar. It was noted the facet distraction/loading maneuvers are moderately positive bilateral at L5-S1 for axial lumbar pain. There was a trace of weakness on hip extension, knee flexion and ankle dorsiflexion of the right side hip extension. The medications included Opana ER 40mg, Colace 100mg, Hydrocodone-Acetaminophen 10/325mg, Neurontin 600mg, and Lisinopril-Hydrochlorothiazide 20/12.5mg. The diagnoses included facet arthropathy, lumbar, sacroiliitis not elsewhere classified, spinal stenosis not otherwise specified, spondylosis not otherwise specified, scar conditions and fibrosis of the skin, lumbar spine, lumbar or lumbosacral disc degeneration, lumbago (low back pain), abnormality of gait, awkward gait, abnormal posture with left side bending-of the lumbar, abnormal posture with guarding of the lower back and hypo

testosterone (Non-industrial). There was no documented evidence of conservative care such as, physical therapy or home exercise regimen outcome improvements noted for the injured worker. The treatment plan included for a decision on Opana ER 40mg, Hydrocodone-Acetaminophen 1/325 mg and Zolpidem 10mg. The request for authorization was submitted on 07/11/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

OPANA ER 40MG QTY: 90.00: 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 request for Opana 40mg # 90 is not medically necessary and appropriate. On 06/11/2014 the injured worker complained of low back pain rated at 9/10. It was noted the pain with medications was a 4/10 and without medications 10/10. The California Medical Treatment Utilization Schedule (MTUS) guidelines state that criteria for use for ongoing- management of opioids include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. There was lack of evidence of opioid medication management and average pain, intensity of pain, or longevity of pain relief. There was no urine drug screen submitted for the injured worker to identify the injured worker ongoing compliance regiment of the Opana ER. In addition, the request does not include the frequency. In addition there was no documented evidence of conservative care such as, physical therapy or home exercise regimen outcome improvements noted for the injured worker. Given the above, the request for the ongoing use of Opana ER 40 mg # 90 is not supported by the California Medical Treatment Utilization Schedule (MTUS) guidelines recommendations. As such, the request for Opana ER 40mg #90 is not medically necessary.

HYDROCODONE-ACETAMINOPHE 10/325MG QTY: 60.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 76-80.

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

Decision rationale: The request for Hydrocodone-Acetaminophen 10/325mg # 60 is not medically necessary and appropriate. On 06/11/2014 the injured worker complained of low back pain rated at a 9 / 10. It was noted the pain with medications was at 4/10 and without medications a 10/10. The California Medical Treatment Utilization Schedule (MTUS) guidelines state that the criteria for ongoing use and management of opioids include the following; review and documentation of pain relief, functional status, appropriate medication use, and side effects of the medication. There was lack of evidence of opioid medication management and average pain,

intensity of pain, or longevity of pain relief. There was no urine drug screen submitted for the injured worker to identify the injured worker ongoing compliance regiment of the Hydrocodone-Acetaminophen 10/325mg. In addition, the request does not include the frequency. There was also no documented evidence of conservative care such as, physical therapy or home exercise regimen outcome improvements noted for the injured worker. Given the above, the request for the ongoing use of Hydrocodone-Acetaminophen is not supported by the California Medical Treatment Utilization Schedule (MTUS) guidelines recommendations. The request for Hydrocodone- Acetaminophen 10/325mg #60 is not medically necessary and appropriate.

ZOPIDEM TARTRATE (AMBIEN) 10MG QTY: 30.00: 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 (Chronic) Zolpidem (AmbienÂ®).

Decision rationale: The request for Zolpidem Tartrate (Ambien) 10 mg # 30 is not medically necessary and appropriate. The Official Disability Guidelines (ODG) states that Ambien is a prescription short-acting non benzodiazepine hypnotic, which is approved for the short-term (usually 2-6 weeks) for treatment of insomnia. Proper sleep is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, 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 concern that they may increase pain and depression over the long-term. The documentation that was submitted for review lacked evidence on the duration the injured worker has been on Ambien. In addition, the request did not include the frequency or duration for the medication for the injured worker. The guidelines do not recommend Ambien for long-term use. Therefore, the continued use of Ambien is not supported. The request for Zolpidem Tartrate (Ambien) is not medically necessary.