

Case Number:	CM14-0121695		
Date Assigned:	08/06/2014	Date of Injury:	01/04/2009
Decision Date:	09/11/2014	UR Denial Date:	07/26/2014
Priority:	Standard	Application Received:	08/01/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 01/04/2009. The mechanism of injury was not provided with the documentation submitted for review. The injured worker's diagnoses were noted to be cervical radiculopathy, cervical disc protrusion and cervical stenosis. He was noted to have had treatments of epidurals, spinal cord stimulator, medications and home exercise. Prior surgical history was noted to be cervical fusion and bilateral shoulder surgeries. The injured worker had a clinical evaluation on 07/31/2014 with subjective complaints of bilateral lower neck pain radiating into the left shoulder, left triceps, left ulnar/forearm and left hand in a radicular pattern with numbness and paresthesias in the bilateral hands. The objective findings were noted to be 2+ edema with tenderness on palpation of the medial left epicondyle. His cervical, elbow and shoulder ranges of motions were restricted by pain in all directions. There was tenderness upon palpation of the right lateral epicondyle. Nerve root tension signs were negative on the right and positive on the left. Clonus, Babinski's and Hoffman's signs were absent bilateral. Muscle strength was 5/5 in the upper extremities, except on the left. Sensation was decreased to light touch, pinprick, proprioception and vibration in the left upper extremity. The treatment was to continue medications. The provider's rationale for the request was indicated in the clinical evaluation on 07/31/2014. The Request for Authorization form is provided within the review and dated 08/01/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325 #100: Upheld

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

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

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines provide 4 domains that are relevant for ongoing monitoring of chronic pain in patients that are on opioids. These include pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. The clinical documentation should include pain relief, functional status, appropriate medication use and side effects. The clinical evaluation on 07/31/2014 fails to provide an adequate pain assessment. It does not note if Percocet is effective in managing the injured worker's symptoms. A urine drug screen was not provided within the documentation submitted for review. In addition, the provider's request fails to provide a dosage frequency. Therefore, the request for Percocet 10/325 quantity 100 is not medically necessary.

Ambien 10mg #30: Upheld

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

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 Official Disability Guidelines note Ambien is a prescription used for the short term 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, also 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 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. The injured worker's assessment fails to provide efficacy with use of Ambien. Long term use is not recommended. In addition, the provider's request fails to provide a dosage frequency. As such, the request for Ambien 10 mg quantity 30 is not medically necessary.