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| Case Number: | CM14-0139709 | | |
| Date Assigned: | 09/05/2014 | Date of Injury: | 12/15/2004 |
| Decision Date: | 10/09/2014 | UR Denial Date: | 07/30/2014 |
| Priority: | Standard | Application Received: | 08/28/2014 |

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 Internal Medicine, and is licensed to practice in California & Illinois. 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 51-year-old female who reported an injury on 12/15/2004. The mechanism of injury was not submitted for clinical review. The diagnoses included S1 radicular pain, opioid dependence, status post anterior cervical discectomy and fusion, status post anterior and posterior lumbar fusion, status post permanent implantation of Medtronic spinal cord stimulator, and failed back syndrome cervical and lumbar spine. The medication regimen included Opana, Percocet, and Ambien. Previous treatments included medication, trigger point injections, surgeries, and spinal cord stimulator. Within the clinical note dated 07/18/2014, it was reported the injured worker complained of back and neck pain status post lumbar and cervical fusion. The injured worker reported neck pain radiating to the right shoulder. The injured worker reported the spinal cord stimulator has helped to reduce pain in the back and legs. Upon physical examination, the provider noted the injured worker was alert. The provider requested Opana ER for low back pain, Percocet for breakthrough pain, and Ambien for sleep, and a spinal cord stimulator reprogram as needed. The Request for Authorization was provided and submitted on 07/18/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Opana ER 15mg, #90: Upheld

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

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

Decision rationale: The request for Opana ER 15 mg #90 is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The provider did not document an adequate and complete pain assessment within the documentation. The provider failed to document an adequate and complete physical examination. The use of a urine drug screen was not submitted for clinical review. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

Percocet 10/325, #60: Upheld

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

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

Decision rationale: The request for Percocet 10/325 mg #60 is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The provider did not document an adequate and complete pain assessment within the documentation. The provider failed to document an adequate and complete physical examination. The use of a urine drug screen was not submitted for clinical review. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

Ambien 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 cite any medical evidence for its decision.

Decision rationale: The request for Ambien 10 mg #30 is not medically necessary. The Official Disability Guidelines note zolpidem is a prescription short acting non-benzodiazepine hypnotic, which was approved for short term, usually 2 to 6 weeks, and treatment for insomnia. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the

medication. Additionally, there is a lack of documentation indicating the injured worker is treated for insomnia. Therefore, the request is not medically necessary.

1 Spinal Cord Simulator Re-Program: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: The request for 1 spinal cord stimulator reprogram is not medically necessary. The California MTUS/ACOEM Guidelines state physician followup can occur when a release to modified, increased, or full duty is needed, or after appreciable healing or recovery can be expected on average. Typically, this will be no more than 1 week into the acute pain period. There is a lack of documentation indicating the need for reprogramming. The provider failed to document a complete and adequate pain assessment within the documentation. The provider failed to document a complete and adequate physical examination. Medical necessity for reprogramming has not been established. Therefore, the request is not medically necessary.