

Case Number:	CM14-0171403		
Date Assigned:	10/23/2014	Date of Injury:	07/29/2008
Decision Date:	11/21/2014	UR Denial Date:	09/18/2014
Priority:	Standard	Application Received:	10/16/2014

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 55-year-old female who reported an injury on 07/29/2008. The mechanism of injury involved a fall. The current diagnoses include thoracic degenerative disc syndrome, lumbar degenerative disc disease, lumbosacral or thoracic neuritis or radiculitis, and sacroiliac ligament sprain/strain. Previous conservative treatment includes home exercise, TENS therapy, medications, physical therapy, activity modification, chiropractic treatment, and a lumbar epidural steroid injection. The current medication regimen includes Ibuprofen, Cyclobenzaprine, Ambien, Omeprazole, and Terocin Topical Analgesic. The injured worker was evaluated on 09/24/2014 with complaints of 6/10 lower back pain, neck pain, and bilateral feet/ankle pain. Physical examination revealed reduced lumbar and cervical range of motion, tenderness to palpation of the cervical spine, reduced grip strength in the left upper extremity, tenderness to palpation in the lumbar spine, and reduced sensation in the right lower extremity. Treatment recommendations included continuation of the current medication regimen. A Request for Authorization form was then submitted on 09/24/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 6.25mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain (updated 09/10/14) Zolpidem (Ambien)

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

Decision rationale: The Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated of the short term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. The injured worker does not maintain a diagnosis of insomnia or sleep disorder. There is no documentation of a failure to respond to non-pharmacologic treatment for insomnia prior to the initiation of a prescription product. There is no frequency listed in the request. Therefore, the request is not medically appropriate.

Cyclobenzaprine 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as nonsedating second line options for short term treatment of acute exacerbations. Cyclobenzaprine should not be used for longer 2 to 3 weeks. There is no documentation of palpable muscle spasm or spasticity upon physical examination. There is also no frequency listed in the request. California MTUS Guidelines do not recommend long term use of muscle relaxants. Therefore, the request is not medically appropriate.

Omeprazole 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (Non-Steroidal Anti-Inflammatory Drugs) GI (Gastrointestina).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermittent or high risk for gastrointestinal events. Patients with no risk factors and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the injured worker does not meet criteria for the use of a proton pump inhibitor. There is also no frequency listed in the request. As such, the request is not medically appropriate.