

Case Number:	CM14-0178588		
Date Assigned:	10/31/2014	Date of Injury:	04/04/1997
Decision Date:	12/08/2014	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/28/2014

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 Physical Medicine & Rehabilitation 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 04/04/1997. The mechanism of injury was cumulative trauma. His diagnoses were noted to include post-cervical laminectomy syndrome, lumbar spine degenerative disc disease, low back pain, shoulder pain, and cervical pain. Past treatment was noted to include medications, epidural steroid injections, and surgery. On 03/26/2014, a urine drug screen reported consistent use of Oxycodone. On 10/27/2014, the injured worker was noted to have complaints of neck pain and back pain which radiated down his bilateral lower extremities. The injured worker stated the medications were working well and did not report any adverse side effects. Upon physical examination, it was noted the injured worker's activities of daily living and pain improved from 5/10 to 2/10 with the use of the medication. He noted that he alternated between Ambien and Ambien CR to maintain efficacy which gave him 3-4 more hours of sleep. His relevant medications were noted to include Remeron 30mg at bedtime, Lidoderm patch 5% every 12 hours as needed, Capsaicin 0.075% cream twice per day as needed, Cymbalta 60mg daily, Medrol 4mg dosepak, Ambien 10mg at bedtime as needed, Ambien CR 12.5mg at bedtime as needed, Oxycodone 10mg daily as needed, and Percocet 10/325mg every 4-6 hours as needed. His treatment plan was noted to include a spinal cord stimulator consultation appointment and medications. A request was received for Ambein10mg #10, Ambien CR 12.5mg #20 plus 1 refill, and Oxycodone 10mg #20 plus 1 refill for sleep disturbances and pain control. The Request for Authorization was signed 11/04/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10mg #10: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Guidelines - Pain: Zolpidem (Ambien (r))

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: According to the Official Disability Guidelines, Ambien is recommended for 7-10 days to treat insomnia. The guidelines also state that adjunctive cognitive behavioral therapy aids in an insomnia treatment plan. The injured worker has been prescribed Ambien since at least 10/2013; therefore continuation of the medication would not be indicated as it exceeds the guideline recommendation for a short course of treatment of 7-10 days. It was also noted the injured worker had not participated in cognitive behavioral therapy for insomnia treatment. There is a lack of documentation which demonstrates that the injured worker had a reduction in the time to sleep onset, improved sleep maintenance, was able to avoid residual effects and had increased next-day functioning. In the absence of cognitive behavioral therapy to aid in an insomnia treatment plan, evidence of improvement in insomnia, and as the request exceeds the guidelines recommendation of 7-10 days of use, the request is not supported by the guidelines. Additionally, the request did not specify duration or frequency of use. As such, the request is not medically necessary.

Ambien CR 12.5mg #20 plus 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Guidelines - Pain: Zolpidem (Ambien (r))

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: According to the Official Disability Guidelines, Ambien is recommended for 7-10 days to treat insomnia. The guidelines also state that adjunctive cognitive behavioral therapy aids in an insomnia treatment plan. The injured worker has been prescribed Ambien since at least 10/2013; therefore continuation of the medication would not be indicated as it exceeds the guideline recommendation for a short course of treatment of 7-10 days. It was also noted the injured worker had not participated in cognitive behavioral therapy for insomnia treatment. There is a lack of documentation which demonstrates that the injured worker had a reduction in the time to sleep onset, improved sleep maintenance, was able to avoid residual effects and had increased next-day functioning. In the absence of cognitive behavioral therapy to aid in an insomnia treatment plan, evidence of improvement in insomnia, and as the request exceeds the guidelines recommendation of 7-10 days of use, the request is not supported by the guidelines. Additionally, the request did not specify duration or frequency of use. As such, the request is not medically necessary.

Oxycodone 10mg #20 plus 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of 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 California MTUS guidelines recommend ongoing review of patient's utilizing chronic opioid medications with documentation of pain relief, functional status, appropriate medication use, and side effects. A complete pain assessment should be documented which includes current pain, the least reported pain over the period since last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The guidelines also recommend providers assess for side effects and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. The injured worker was noted to have a reduction in pain with the use of this medication and a greater ability to perform his activities of daily living. The injured worker did not note any adverse side effects from the medication and it was noted that his urine drug screen showed consistent use of the pain medication being requested. The request is supported by the guidelines in that proper documentation demonstrating pain relief, improved ability to perform activities of daily living, adverse side effects, and a urine drug screen were noted. However, the request did not specify the duration or frequency of use for Oxycodone 10mg. As such, the request is not medically necessary.