

<b>Case Number:</b>	CM14-0020541		
<b>Date Assigned:</b>	05/02/2014	<b>Date of Injury:</b>	08/07/2001
<b>Decision Date:</b>	07/24/2014	<b>UR Denial Date:</b>	02/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/19/2014

### 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 Occupational Medicine, 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 patient is a 54-year-old female who has submitted a claim for thoracic/lumbosacral neuritis/radiculitis, postlaminectomy syndrome lumbar region, lumbosacral spondylosis without myelopathy, lumbosacral intervertebral disc degeneration, cervicalgia, intervertebral lumbosacral disc disorder with myelopathy, pain in soft tissues of the limb, lumbago, and unspecified meningitis associated with an industrial injury date of August 7, 2001. Medical records from 2013 were reviewed. The patient complained of chronic, severe low back pain, rated 8/10 in severity. The pain radiates to the right leg with continued numbness and tingling in the feet bilaterally. Physical examination showed tenderness over the lumbar paraspinals and L5-S1 area. There was limited range of motion. Straight leg raise test was positive on both sides. Motor strength and sensation was decreased on the right lower extremity. Imaging studies were not made available. Treatment to date has included medications, physical therapy, home exercise program, and activity modification.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **OXYCONTIN 40 MG XR 12 HOUR TAB 1-2 THREE TIMES A DAY AS NEEDED:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 81.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

**Decision rationale:** As stated on page 78 of the California MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief (analgesia), side effects (adverse side effects), physical and psychosocial functioning (activities of daily living aka ADLs), and the occurrence of any potentially aberrant drug-related 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. In this case, patient has been taking Oxycontin since November 5, 2013. The most recent progress report, dated April 22, 2014, showed decreased pain from 8/10 to 2/10 with medications. It also states that the medications are keeping the patient functional, allowing for increased mobility, and tolerance of ADLs and home exercises. There were no side effects noted. Urine drug screening was noted to be appropriate. The guideline criteria were met. However, the present request failed to specify the quantity to be dispensed. Therefore, the request is not medically necessary.

**AMBIEN 10 MG TABS (ZOLPIDEM TARTRATE) EVERY NIGHT AT BED TIME AS NEEDED INSOMNIA:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

**Decision rationale:** The California MTUS does not specifically address this issue. The Official Disability Guidelines state that zolpidem (Ambien) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. In this case, the patient was taking Ambien since November 2013. She has been taking the medication once a month. Long-term use of the medication is not recommended. Furthermore, there was no mention regarding the patient's sleeping habits that warrant the use of Ambien. Moreover, the quantity was also not specified on the request. Therefore, the request is not medically necessary.

**ROXICODONE 30 MG TABS (OXYCODONE HCL) EVERY FOUR HOURS AS NEEDED:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

**Decision rationale:** As stated on page 78 of the California MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief

(analgesia), side effects (adverse side effects), physical and psychosocial functioning (activities of daily living aka ADLs), and the occurrence of any potentially aberrant drug-related 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. In this case, patient has been taking Roxicodone since November 5, 2013. The most recent progress report, dated April 22, 2014, showed decreased pain from 8/10 to 2/10 with medications. It also states that the medications are keeping the patient functional, allowing for increased mobility, and tolerance of ADLs and home exercises. There were no side effects noted. Urine drug screening was noted to be appropriate. The guideline criteria were met. However, the present request failed to specify the quantity to be dispensed. Therefore, the request is not medically necessary.