

Case Number:	CM14-0023654		
Date Assigned:	06/11/2014	Date of Injury:	06/10/2008
Decision Date:	07/15/2014	UR Denial Date:	01/30/2014
Priority:	Standard	Application Received:	02/25/2014

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:

This 62 year-old patient sustained an injury on 6/10/08. Report for reconsideration of 2/13/14 from the provider noted patient with chronic neck pain radiating to bilateral upper extremities and low back pain radiating to bilateral lower extremities. Exam noted cervical spine with tenderness in the paravertebral area on palpation; decreased sensory in right C5-6 dermatome with moderate limitation in range of motion due to pain along with tenderness of L4-S1 paravertebral area; and tenderness at right anterior shoulder. It was noted the MRI of the cervical spine consistent with radiculopathy; positive response to previous cervical epidural with 60% pain relief for 2 months. Diagnoses included cervical radiculopathy; lumbar radiculopathy; lumbar facet arthropathy; chronic pain; s/p right shoulder arthroscopy x 3; s/p Lap Band surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT C4-C6 CERVICAL EPIDURAL STEROID INJECTION (ESI): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines recommend ESI as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Radiculopathy must be documented on physical examination and corroborated by imaging studies and/or Electrodiagnostic testing not specifically defined with documented objection readings provided. The patient also had undergone previous cervical epidural injections as noted by the provider and was noted with pain relief; however, submitted reports have not adequately demonstrated any long-term significant pain relief or functional improvement in ADLs from prior injection rendered as symptom complaints, pain level, clinical findings and pain medication dosing remained unchanged along with unchanged work and functional status. The right C4-C6 cervical epidural steroid injection is not medically necessary and appropriate.

RESTONE 300MG CAPS (MELATONIN-TRYPTOPHAN) #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Insomnia.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head, Sleep Aids, and Mental & Stress, Insomnia Treatment.

Decision rationale: Regarding sleep aids, ODG states that preliminary evidence demonstrates the value of Melatonin in treating sleep disorder post-TBI; however, there are documented diagnoses of such. Submitted reports have not demonstrated any evidence-based studies or medical report to indicate necessity of the above treatment. There is no report of sleep disorder. In order to provide a specific treatment method, the requesting physician must provide clear objective documentation for medical indication, functional improvement goals' expected or derived specifically relating to the patient's condition as a result of the treatment(s) provided. Documentation of functional improvement may be a clinically significant improvement in activities of daily living, a reduction in work restrictions and a reduction in the dependency on continued medical treatment. Absent the above described documentation, there is no indication that the specific treatment method is effective or medically necessary for this patient. The Restone 300mg #30 is not medically necessary and appropriate.

ZOLPIDEM 10MG #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), Insomnia.

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

Decision rationale: Per the ODG, this non-benzodiazepine CNS depressant is the treatment of choice in very few conditions with tolerance to hypnotic effects developing rapidly with

anxiolytic effects occurring within months; limiting its use to 4 weeks as long-term use may actually increase anxiety. Submitted reports have not demonstrated any clinical findings or specific sleep issues such as number of hours of sleep, difficulty getting to sleep or staying asleep or how use of this sedative/hypnotic has provided any functional improvement from treatment already rendered. The zolpidem 10mg #30 is not medically necessary and appropriate.

NORCO 10/325MG #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: Per the MTUS Guidelines cited, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant therapies, psychological support, and active treatments (e.g., exercise). Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or change in work status. The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with persistent severe pain. The Norco 10/325mg #120 is not medically necessary and appropriate.