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| Case Number: | CM14-0026432 | | |
| Date Assigned: | 06/13/2014 | Date of Injury: | 02/20/1999 |
| Decision Date: | 07/17/2014 | UR Denial Date: | 02/20/2014 |
| Priority: | Standard | Application Received: | 03/03/2014 |

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 and Rehabilitation, has a subspecialty in Pain Medicine, 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 54-year-old female who reported an injury on 2/20/99. The mechanism of injury was reported as continuous trauma. The clinical note dated 1/3/14 stated that the injured worker presented with complaints of pain to the lower back with radicular symptoms into the legs. Upon exam, the lumbar revealed tightness in the lumbar paraspinal musculature. The diagnoses included a herniated lumbar disc with radiculitis, anterolisthesis of L5 over S1, right shoulder strain, and left shoulder strain. Prior treatment included therapy and medications, the injured worker stated the medications had been of benefit. The provider recommended Norco 10/325 mg, Ultram ER 150 mg, and Ambien 10 mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO 10/325 MG #360: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-80.

Decision rationale: Regarding opioid management, the California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The injured worker had been prescribed Norco since at least 5/18/12, and noted her medications had been of benefit. There are no numerical pain values to validate that statement. There is a lack of evidence regarding an objective assessment of the injured worker's pain level, functional status, and side effects to determine the necessity of continued use. In addition, the submitted request does not indicate the frequency of the medication. As such, the request is not medically necessary.

ULTRAM ER 150 MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-80.

Decision rationale: Regarding opioid management, the California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The injured worker had been prescribed Ultram since at least 5/18/12, and noted her medications had been of benefit. There are no numerical pain values to validate that statement. There is a lack of evidence regarding an objective assessment of the injured worker's pain level, functional status, and side effects to determine the necessity of continued use. In addition, the submitted request does not indicate the frequency of the medication. As such, the request is not medically necessary.

AMBIEN 10 MG #90: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

Decision rationale: The Official Disability Guidelines state that Ambien is a prescription short acting non-benzodiazepine hypnotic, which is approved for the short term, usually 2-6 weeks, of treatment for insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely recommend them for long term use. They can be habit forming, and they may impair function and memory more than opioid pain relievers. There is a concern that they may increase pain and depression over the long term. The included medical documents lack evidence of insomnia symptoms or a diagnosis of insomnia. It is not noted if the injured worker is having difficulty with sleep onset, maintenance, quality of sleep, or next day functioning. The documentation did not provide information of whether Ambien was a continued medication or a new prescription; the 4/2/14 progress report does not list it with her medications. The request for

Ambien 10 mg with a quantity of 90 would translate to a three month supply of the medication, and would exceed the guideline recommendation of short term use. The provider's request did not indicate the frequency of the medication. As such, the request is not medically necessary.