

Case Number:	CM14-0031855		
Date Assigned:	06/16/2014	Date of Injury:	04/25/2008
Decision Date:	07/21/2014	UR Denial Date:	02/26/2014
Priority:	Standard	Application Received:	03/06/2014

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, 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 51-year-old female who reported an injury on 04/25/2008. The mechanism of injury was not provided for review. The injured worker reportedly sustained an injury to the low back. The injured worker's treatment history included multiple medications and physical therapy. The injured worker was evaluated on 12/30/2013. It was documented that the injured worker's medications included cyclobenzaprine, hydrocodone, omeprazole, meloxicam, and methocarbamol. It was documented that the patient had low back pain rated 8/10 that radiated into the right lower extremity. Physical findings included a positive straight leg raising test to the right at 45 degrees and to the left at 60 degrees. The injured worker's diagnoses included musculoligamentous sprain of the lumbar spine with lower extremity radiculitis, chronic right L5 radiculitis, and status post cauda equina epidural steroid injection. The injured worker's treatment plan included continued medications and aquatic therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

ZOLPIDEM 10 MG #30, 1 HS, PRN: Upheld

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

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, Insomnia Treatment.

Decision rationale: The requested Zolpidem 10 mg #30, one at bedtime as needed is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 08/2013. It is noted within the documentation that the injured worker takes this medication on an as needed basis and not on a nightly schedule. The California Medical Treatment Utilization Schedule does not specifically address this medication. The Official Disability Guidelines recommend the use of this medication to assist with sleep hygiene and insomnia related to chronic pain. The most recent clinical documentation submitted for review does not provide an adequate assessment of the patient's sleep hygiene to support that pharmacological intervention continues to be required. Therefore, ongoing use of this medication would not be supported. As such, the requested Zolpidem 10 mg #30, one at bedtime as needed is not medically necessary or appropriate.

TRAMADOL 50 MG #200, 1-2 QID PRN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 83-84.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The requested tramadol 50 mg #200, one to two 4 times a day as needed is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the ongoing use of this medication be supported by documentation of a functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation does indicate that the injured worker has been on this medication since at least 08/2013. However, the clinical documentation fails to provide any evidence of a quantitative assessment of pain relief or functional benefit related to the use of this medication. Additionally, there is no documentation that the patient is regularly monitored for aberrant behavior. Therefore, continued use of this medication would not be supported. Therefore, the requested tramadol 50 mg #200, one to two 4 times a day as needed is not medically necessary or appropriate.