

Case Number:	CM14-0032081		
Date Assigned:	03/21/2014	Date of Injury:	02/22/2007
Decision Date:	05/28/2014	UR Denial Date:	02/26/2014
Priority:	Standard	Application Received:	03/13/2014

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 Anesthesiology and is licensed to practice in Massachusetts, Connecticut and Texas. 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 claimant is a 39 year-old female who is reported to have sustained a work related injury on 02/22/2007. Records indicate the patient is status post a left sided L5/S1 decompression and discectomy performed on 08/21/07. The patient later underwent an ALIF at L5/S1 on 07/10/09. Postoperatively, the patient had continued low back pain with the new onset of left lower extremity pain and radiculopathy confirmed by EMG/NCV. The patient underwent additional LESI without benefit. The patient was ultimately diagnosed with a Failed Back Surgery Syndrome (FBSS). The most recent clinical note dated 02/13/14 indicates the patient has continued low back pain with radiation into the left lower extremity. The patient's medication profile is reported to be moderately effective. She reports the side-effect of constipation. On physical examination the patient is 5 feet four inches tall with a BMI of 50. There is pain in the bilateral paraspinal musculature, reduced lumbar range of motion, 5/5 motor strength, positive SLR on the left. DTR 's are $\hat{A}1/4$ and symmetric at the patella. The patient is reported to not be a surgical candidate and information was provided regarding Spinal Cord Stimulation.

IMR ISSUES, DECISIONS AND RATIONALES

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

AMITIZA 24MCG, #60: 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 Amitiza Package Insert.

Decision rationale: The patient has a FBSS and has been chronically maintained on opiate medications. As a side effect, the patient report constipation. Per the package insert and FDA prescribing information, AMITIZA (lubiprostone) 24 mcg capsules twice daily is approved to treat Chronic Idiopathic Constipation (CIC) in adults. Idiopathic means the cause of the constipation is unknown and not due to an underlying illness or medication. As the patient does not carry the indicated diagnosis, the request cannot be supported as medically necessary.

FENTANYL 25MCG, #10: 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), Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80.

Decision rationale: The records do not provide any data to establish the efficacy of this medication. The records do not contain VAS scores or documentation of functional improvements as a result of this medication, as would be required by MTUS guidelines. There is no documentation of UDS to assess compliance. In the absence of this data the medical necessity is not established for continued use of this medication.

NORCO 10/325MG, #120: 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), Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80.

Decision rationale: The records do not provide any data to establish the efficacy of this medication. The records do not contain VAS scores or documentation of functional improvements as a result of this medication, as would be required by MTUS guidelines. There is no documentation of UDS to assess compliance. In the absence of this data the medical necessity is not established for continued use of this medication.

ZOLPIDEM 10MG, #30: Upheld

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

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

Decision rationale: The records do not provide any data to establish the efficacy of this medication. ODG does not support or recommend the chronic use of Zolpidem. Per the ODG, Zolpidem is recommended for 2 to 6 weeks to restore a normal sleep pattern and then be discontinued. There is no data presented to establish extenuating circumstances. Therefore, the medical necessity is not established for continued use of this medication.