

Case Number:	CM14-0033950		
Date Assigned:	07/16/2014	Date of Injury:	06/11/2009
Decision Date:	08/14/2014	UR Denial Date:	03/01/2014
Priority:	Standard	Application Received:	03/14/2014

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:

Injured worker is a female with date of injury 6/11/2009. Per workers' comp pain management re-evaluation and request for authorization dated 1/30/2014, the injured worker complains of low back pain. She indicates she is having very little leg pain, most of her pain is right in the lower part of her back at the midline, slightly more to the left. She states that she has been out of any medication for an extended period of time. She states she was taking Cymbalta which seemed to take the edge off of the pain and make her feel somewhat better on a regular basis although she did have days that the pain was worse and she is still having problems with insomnia. On exam she has significant tenderness over the L4-L5, L5-S1 facets bilaterally, slightly more on the left. She has a positive facet loading test with 3+ pain to left, 2+ pain to right. Straight leg raising is negative today to both left and right. She has some associated low back pain. Neurologically, deep tendon reflexes, motor function is intact. Fabere's test causes slight pain, compression test causes some slight pain as well. Diagnoses include 1) axial low back pain, 2) lumbar discogenic disease, 3) 2.5 mm disc protrusion annular tear L3-4, 4 mm disc protrusion L4-5, 3.5 mm disc protrusion L5-S1, 4) lumbar facet arthropathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol PO 50 mg once daily #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for Neuropathic Pain section and Opioids, specific drug list section Page(s): 82, 83, 93, 94.

Decision rationale: The MTUS Guidelines state that tramadol is not recommended as a first-line oral analgesic. There is no medical documentation to support the use of tramadol provided by the requesting provider. The injured worker is noted to not have had any medicine for an extended period of time. There is no use of VAS rating her pain, or the improvement seen with pain medications. She is also noted to report that the use of Cymbalta provided her pain relief, but the efficacy of other medications is not reported. The injured worker is also noted to have made a request for Cymbalta, which was approved by the claims administrator. The request for tramadol PO 50 mg once daily #60 is determined to not be medically necessary.

Ambien 10 mg #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 Official Disability Guidelines (ODG), Pain, Insomnia Treatment section, Zolpidem (Ambien) section.

Decision rationale: The use of Ambien is not addressed by the MTUS Guidelines. The ODG reports that Ambien is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbances. There is no evidence that sleep hygiene and causes of insomnia have been addressed adequately to support the use of Ambien. The request for Ambien 10 mg #60 is determined to not be medically necessary.