

Case Number:	CM14-0045591		
Date Assigned:	06/27/2014	Date of Injury:	04/24/2006
Decision Date:	08/18/2014	UR Denial Date:	03/31/2014
Priority:	Standard	Application Received:	04/03/2014

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 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:

The injured worker is a 47-year-old female who reported an injury on 04/24/2006, due to an unspecified mechanism of injury. On 03/17/2014, she reported continued lower back pain rated at a 4/10 and numbness on the right lower extremity rated at a 3/10. A physical examination of the lumbar spine and lower extremities revealed no evidence of weakness, tenderness to palpation was noted over the paravertebral muscles bilaterally, there was decreased sensation on the right S1 dermatome, and a positive straight leg raise of the right lower extremity. Range of motion was documented as flexion to 58/60 degrees, extension 9/25 degrees, left lateral bend 14/25 degrees, and right lateral bend 12/25 degrees, pain was noted with range of motion. She had +2 reflexes in the knees and ankles, and 5/5 motor strength throughout. Her diagnoses were listed as status post successful spinal cord stimulator trial, L3-4 disc displacement, right leg radiculopathy, status post removal of fractured S1 screw, L3-4 and L4-5 pseudoarthrosis, and status post revision of the L3-5 fusion. Her medications included Ambien CR 12.5 mg, Norco 10/325 mg tablets 5 times a day, promethazine 25 mg tablet, Zanaflex 6 mg capsule, Valium 5 mg tablet 3 times a day, and methadone HCL 10 mg tablet. Past treatments included medications and a spinal cord stimulator trial. The treatment plan was for hydrocodone/APAP 10/325 mg, quantity 180; methadone 10 mg, quantity 180; Valium 5 mg, quantity 60, and Ambien 12.5 mg, quantity 30. The Request for Authorization form was signed on 03/17/2014. The rationale for treatment was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/APAP 10/325mg, #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, pain treatment agreement Page(s): 89.

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

Decision rationale: The request for hydrocodone/APAP, 10/325mg, #180, is non-certified. Per the clinical note dated 03/17/2014, the injured received a refill of Norco 10/325mg tablets. She reported continued low back pain rated at a 4/10 and numbness on the right lower extremity rated at a 3/10. The California MTUS guidelines state that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be performed at every office visit during opioid therapy. Pain assessment should include current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Based on the clinical information submitted for review, the injured worker had received a refill of Norco 10/325mg tablets. It was not stated how long the she had been taking this medication. There is a lack of documentation regarding appropriate medication use, adverse side effects, and an appropriate pain assessment. Without proven efficacy of the medication, the request for extended use would not be supported. In addition, the requesting physician did not specify the frequency of the medication within the request. The request is not supported by the guideline recommendations, as there is no documented evidence of efficacy and the frequency of the medication was not provided. Given the above, the request is non-certified.

Methadone 10mg, #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, pain treatment agreement Page(s): 89.

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

Decision rationale: The request for methadone 10 mg, quantity 180, is non-certified. On 03/17/2014, the injured worker reported continued low back pain rated at a 4/10, and numbness in the right lower extremity rated at a 3/10. She was noted to have decreased range of motion and a positive straight leg raise to the right lower extremity. The California MTUS Guidelines state that ongoing management of opioid therapy should include an ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain, the least reported pain over the period since last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Based on the clinical information submitted for review, the injured worker received a refill of methadone HCL 10 mg tablets. It was not stated how long the she had been taking this medication. There is a lack of documentation regarding objective functional improvement, adverse side effects, and screening for aberrant drug taking behaviors with the use of this medication. In addition, the requesting physician did not specify the

frequency of the medication within the request. The request is not supported by the guideline recommendations, as there is no documented evidence of efficacy or a proper medication assessment to support continued use. Given the above, the request is non-certified.

Valium 5mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The request for Valium 5mg, quantity #60, is non-certified. On 03/17/2014, the injured worker reported continued low back pain rated at a 4/10 and numbness in the right lower extremity rated at a 3/10. She was noted to have decreased range of motion and decreased sensation in the S1 dermatome. The California MTUS Guidelines state that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Based on the clinical information provided for review, the injured worker had received a refill of Valium 5 mg tablets on 03/17/2014. It was not stated how long she had been taking this medication. Without knowing the length of treatment with this medication, extended use cannot be supported as it is not recommended for long term use. In addition, there was no objective functional improvement documented with the use of this medication. Furthermore, the requesting physician did not specify the frequency of the medication within the request. The documentation provided is lacking information regarding length of treatment, evidence of efficacy, and the frequency of the medication; and therefore, is not supported by the guideline recommendations. Given the above, the request is non-certified.

Ambien 12.5 mg quantity 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), Pain, Zolpidem (Ambien).

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

Decision rationale: The request for Ambien 12.5 mg, #30, is non-certified. On 03/17/2014, the injured worker reported low back pain and numbness in the right lower extremity. She was noted to have decreased range of motion, decreased sensation in the right S1 dermatome, and a positive straight leg raise on the right. The California MTUS/ACOEM Guidelines do not specify this topic. The Official Disability Guidelines state that Ambien is a prescription short-acting benzodiazepine hypnotic which is approved for the short-term use of treatment for insomnia. Treatment is usually recommended for 2 to 6 weeks. Based on the clinical information submitted for review, the patient received a refill of this medication on 03/07/2014, and there were no reports of her having trouble sleeping or insomnia. The rationale for the use of this

medication is unclear, as it does not appear that the patient had any trouble sleeping or reports of insomnia. In addition, it is unclear how long the patient has been using Ambien, as it appears she had a refill on 03/17/2014, and this medication is only recommended for short-term use. Furthermore, the requesting physician did not specify the frequency of the medication within the request. The request is not supported by the guideline recommendations as it is unclear how long she had been taking it and there are no clear indications for its necessity. Given the above, the request is non-certified.