

Case Number:	CM14-0048513		
Date Assigned:	06/25/2014	Date of Injury:	05/17/2013
Decision Date:	08/29/2014	UR Denial Date:	03/19/2014
Priority:	Standard	Application Received:	03/28/2014

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 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 45-year-old female who reported an injury on 05/17/2013. The mechanism of injury was not provided within the documentation submitted. The injured worker's diagnoses were noted to be left carpal tunnel syndrome and right wrist pain following carpal tunnel release. The injured worker's prior treatments were noted to be splinting and home exercises. Her pertinent diagnostics were noted to be an EMG of the bilateral upper extremities. The injured worker was noted to have surgical history of right-sided revision carpal tunnel release. The injured worker had a clinical evaluation on 02/10/2014 with subjective complaints of left-sided upper extremity pain and numbness. She indicated an aching pain in her left shoulder and pain in her left wrist. Pain was rated a 6/10. The objective physical exam findings revealed no sign of any swelling, no atrophy of the left wrist. Dorsiflexion was 70 degrees, volar flexion was 70 degrees, radial deviation was 20 degrees, and ulnar deviation was 30 degrees. There was no sign of carpal instability. Strength was 5/5. The inspection and palpation of the right wrist noted the incision was healing well. There was no erythema or drainage. There was a mild decrease in sensation in the median nerve distribution. There was no sign of right upper extremity lymphedema. The injured worker was noted to use Norco for symptom relief. The treatment plan noted refill of medications. The provider's rationale for the request was partially submitted. The Request for Authorization form was provided with this review and dated 02/10/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10 mg #30 with three refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability 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, Zolpidem (Ambien®).

Decision rationale: The request for Ambien 10 mg quantity 30 with 3 refills is not medically necessary. The Official Disability Guidelines indicate Ambien as a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually 2 to 6 weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. The documentation submitted for review fails to indicate a diagnosis of insomnia. The injured worker did not have subjective complaints of insomnia. The guidelines only recommend 2 weeks of Ambien therapy. The provider's request fails to indicate a dosage frequency. As such, the request for Ambien 10 mg at 30 with 3 refills is not medically necessary.

Norco 10/325mg #90 with 3 refills: Upheld

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

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

Decision rationale: The request for Norco 10/325 mg quantity 90 with 3 refills is not medically necessary. The Chronic Pain Medical Treatment Guidelines provide 4 domains that are relevant for the ongoing monitoring of chronic pain patients on opioids. These include pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the 4 A's (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. The documentation submitted for review fails to include an adequate pain assessment. The clinical documentation should include 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 opiates; how long it takes for pain relief; and how long the pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The provider's request fails to provide a dosage frequency. Therefore, the request for Norco 10/325 mg quantity 30 with 3 refills is not medically necessary.

(1) Re-Evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The request for 1 re-evaluation is not medically necessary. The Official Disability Guidelines rotator cuff office visits as determined to be medically necessary. Evaluation and management outpatient visits to the offices of medical doctors play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a healthcare provider is individualized based upon a review of the patient's concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications are being taken, since some medications such as opiates, or medicines such as certain antibiotics, require close monitoring. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the healthcare system as soon as clinically feasible. Based upon the documentation submitted for review, objective data and the treatment plan; the medical necessity for a re-evaluation is not warranted. Therefore, the request for 1 re-evaluation is not medically necessary.