

Case Number:	CM14-0095031		
Date Assigned:	07/25/2014	Date of Injury:	08/11/2003
Decision Date:	09/29/2014	UR Denial Date:	06/19/2014
Priority:	Standard	Application Received:	06/23/2014

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 & Rehabilitation and is licensed to practice in Nevada. 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 records presented for review indicate that this 59-year-old gentleman was reportedly injured on August 11, 2003. The mechanism of injury is listed as having a mechanical roller go across the dorsal aspect of his right hand. The most recent progress note, dated March 4, 2014, indicates that there are ongoing complaints of neck pain radiating down the left upper extremity. The physical examination demonstrated no tenderness or spasms of the cervical spine or trapezius muscles. There was decreased cervical spine range of motion. There was a normal upper extremity neurological examination. Diagnostic imaging studies of the cervical spine show evidence of prior fusion at C4-C7. No subluxation is seen and hypertrophic spurring of the end plates is minimal. Previous treatment includes cervical spine surgery to include a decompression and fusion at C4 - C5 and C5 - C6 as well as nerve root blocks and radiofrequency facet ablations. There has also been treatment with group therapy and psychological counseling. A request had been made for Kadian, oxycodone, and Ambien and was not certified in the pre-authorization process on June 19, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

KADIAN 80MG #45: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 74-96.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-75, 78, 93.

Decision rationale: Kadian is a brand name of morphine. The California MTUS Guidelines support long-acting opiates in the management of chronic pain when continuous around-the-clock analgesia is needed for an extended period of time. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The injured employee has pain; however, there is no documentation of improvement in their pain level or function with the current treatment regimen. In the absence of subjective or objective clinical data, this request for Kadian is not medically necessary.

OXYCODONE 15MG #100: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 92.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74, 78, 93.

Decision rationale: The California MTUS Guidelines support short-acting opiates for the short-term management of moderate to severe breakthrough pain. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The injured employee has chronic pain; however, there is no clinical documentation of improvement in their pain or function with the current regimen. As such, this request for oxycodone 15 mg is not medically necessary.

AMBIEN CR 3.25MG: 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) - TWC/ODG Integrated Treatment/Disability Duration Guidelines; Pain (Chronic) - Ambien (updated 09/10/14).

Decision rationale: Zolpidem (Ambien) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. The guidelines specifically do not recommend them for long-term use for chronic pain. This request for Ambien does not indicate how many tablets are prescribed as an indication of the length of treatment. As such, this request for Ambien CR 3.25 mg is not medically necessary.