MAXIMUS Federal Services

Case Number:	CM14-0097380		
Date Assigned:	07/28/2014	Date of Injury:	11/21/1998
Decision Date:	09/26/2014	UR Denial Date:	06/04/2014
Priority:	Standard	Application Received:	06/25/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in 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 injured worker is an 83 year old female who had a work related injury on 11/12/98. Mechanism of injury was not documented. Most recent clinical documentation submitted for review was dated 05/28/14. The patient was in for chronic low back pain symptoms. She rated her pain 5/10. Average pain score was 2-5/10. Pain was constant but variable in intensity. She had bilateral lower extremities weakness. Stiffness of low back pain, spasm of low back, and interference with sleep. Aggravating factors were bending, carrying and climbing stairs, driving, lumbar side bending and weather changes. Alleviated by exercises, physical therapy medication, rest and epidural steroid injections. Epidural steroid injection with significant improvement with 75% improvement with regards to pain and increased function for a year she had last one on 03/29/14. She used Ultracet with moderate improvement, could not take towards the evening. On physical examination gait was normal. Posture was normal. No trigger points or tenderness or muscle spasm in low back pain. Lumbar spine range of motion within normal limits except for flexion which was limited to 25 degrees. Extension 5 degrees. Right sided bending 10 degrees and left side bending. Negative straight leg raise bilaterally. Able to rise on toes and heels. EHL was intact. Diagnosis lumbosacral spine spondylosis without myelopathy. Current medication is Ambien 5mg tablets, gabapentin 400mg capsules, hydrocodone 5/325 tablets, Lidoderm 5% patch, and Ultracet 37.5mg/325. Prior utilization review on 06/04/14 was modified to initiate tapering.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultracet 37.5mg-325mg tablet QTY 60 refills 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: Current evidenced-based guidelines indicate patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is insufficient documentation regarding the functional benefits and functional improvement obtained with the continued use of narcotic medications. Documentation does not indicate a significant decrease in pain scores with the use of medications. As such, the request is not medically necessary.

Ambien 5mg tablet QTY 30 refills 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. 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 ODG TreatmentIntegrated Treatment/Disability Duration GuidelinesPain (Chronic)Zolpidem (AmbienÂ®).

Decision rationale: As noted in the Pain (Chronic) of the Official Disability Guidelines (ODG) - online version, Ambien is approved for the short-term (usually two to six weeks) treatment of insomnia. Pain specialists rarely, if ever, recommend it for long-term use. Ambien can be habit-forming, and may impair function and memory more than opioid pain relievers. There is also concern that it may increase pain and depression over the long-term. The patient has been utilizing this medication on a long-term basis, exceeding the recommended 2-6 week window of use. As such, the request for Ambien 5 mg is not medically necessary.

Hydrocodone 5mg acetaminophen 325mg QTY 30 refills 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: Current evidenced-based guidelines indicate patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is insufficient documentation regarding the functional benefits and functional improvement obtained with the continued use of narcotic medications. Documentation does not indicate a significant decrease in pain scores with the use of medications. As such, the request is not medically necessary. However, these medications

cannot be abruptly discontinued due to withdrawal symptoms, and medications should only be changed by the prescribing physician.