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| Case Number: | CM15-0001516 | | |
| Date Assigned: | 01/12/2015 | Date of Injury: | 07/26/2007 |
| Decision Date: | 03/13/2015 | UR Denial Date: | 12/30/2014 |
| Priority: | Standard | Application Received: | 01/05/2015 |

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 62-year-old male who reported an injury on 07/26/2007. The mechanism of injury was not provided. On 11/10/2014, the injured worker presented with low back pain increased from 6/10 up to 7/10 to 8/10 and pain in the lower extremity. Diagnoses were musculoskeletal sprain of the cervical, thoracic, and lumbar spine; facet hypertrophy at the L4-5 bilaterally; and disc bulge 3 mm at the L3-4 and L4-5 with mild bilateral neural foraminal narrowing. Prior treatment included medications. The provider recommended Ambien, Robaxin, and Tylenol No. 4. There was no rationale provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien (dosage/quantity unspecified): 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

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

Decision rationale: The request for Ambien (dosage/quantity unspecified) is not medically necessary. The Official Disability Guidelines state that Ambien is a prescription short acting nonbenzodiazepine hypnotic which is approved for the short term, usually 2 to 6 week, treatment of insomnia. Sleep hygiene is critical to the individual with chronic pain and often hard to obtain. Sleeping pills, so called minor tranquilizers, and antianxiety agents are commonly prescribed in chronic pain; pain specialists rarely, if ever, recommend them for long term use. They can be habit forming, and they may impair function and memory more than opioid pain relievers. There is also a concern that they may increase pain and depression over the long term. Although the patient has a diagnosis of insomnia, the efficacy of the prior use of Ambien was not provided to support continued use. There were no subjective or objective symptoms noted. Additionally, there is no information on treatment history and length of time the injured worker has been prescribed Ambien, and the guidelines do not support long term use. Provider's request does not indicate a dose, quantity, or frequency of the medication in the request as submitted. As such, medical necessity has not been established.

Robaxin (dosage/quantity unspecified): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Robaxin Page(s): 65.

Decision rationale: The request for Robaxin (dosage/quantity unspecified) is not medically necessary. The California MTUS recommends Robaxin for short course of therapy. The mechanism of action is unknown, but appears to be related to the central nervous system. There is no information on treatment history or length of time the injured worker has been prescribed Robaxin. Additionally, efficacy of the prior use of the medication was not provided to support continued use. The provider does not indicate a dose, quantity, or frequency of the medication in the request as submitted. As such, medical necessity has not been established.

Tylenol No.4: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 78.

Decision rationale: The request for Tylenol No.4 is not medically necessary. The California MTUS Guidelines state that opioids are recommended for ongoing management of chronic pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is lack of documentation of an objective assessment of the injured worker's pain level, functional status, appropriate medication use, and side effects. Current urine drug screen and signed pain contract was not

submitted for review. Additionally, there is no information on treatment history or length of time the injured worker has been prescribed Tylenol No. 4. The provider does not indicate a dose or frequency of the medication in the request as submitted. As such, medical necessity has not been established.