

Case Number:	CM15-0006429		
Date Assigned:	01/26/2015	Date of Injury:	05/24/2000
Decision Date:	03/11/2015	UR Denial Date:	12/18/2014
Priority:	Standard	Application Received:	01/12/2015

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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular Medicine

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 60 year old female who sustained an industrial related injury on 5/24/00. The injured worker had complaints of neck and arm pain. The injured worker underwent cervical fusion from C4-C7. Prescriptions included Metformin, Atenolol, Simvastatin, Protonix, Amlodipine, Benazepril, Ambien, Nortriptyline, and Percocet. Diagnoses included arthrodesis C4-7, neuropathic pain, post laminectomy syndrome, cervical stenosis, and cervical degenerative disc. Physical examination findings included cervical flexion was 50% of full flexion with increased pain and cervical extension was 25% of full extension with increased pain. Cervical rotation was 50% in each direction with increased pain. Sensory was decreased in the left C6-7 areas. The treating physician requested authorization for Percocet 5/325mg #90 with 2 refills and Ambien 10mg #30 with 1 refill. On 12/18/14 the request for Percocet was modified and the request for Ambien was non-certified. Regarding Percocet, the utilization review (UR) physician cited the Medical Treatment Utilization Schedule guidelines and noted the documentation does not identify quantifiable pain relief and functional improvement. Therefore the request was modified to a 1 month supply for weaning purposes. Regarding Ambien, the UR physician cited the Official Disability Guidelines and noted the medication was recommended for short term use and that it can be habit forming. Therefore the request was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 5/325 mg, ninety count with two refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the Use of Opioids Section.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ongoing management Page(s): 78-80.

Decision rationale: Percocet 5/325 mg, ninety count with two refills is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS guidelines recommends the 4 A's for ongoing monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: 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 drugtaking 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 MTUS Chronic Pain Medical Treatment Guidelines state that a 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. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The documentation submitted does not reveal evidence of the above pain assessment and monitoring per the MTUS Guidelines therefore this request is not medically necessary.

Ambien 10 mg, thirty count with one refill: 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 Chapter, Zolpidem (Ambien) Section

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain (chronic)

Decision rationale: Ambien 10mg thirty count is not medically necessary per the ODG guidelines. The MTUS Guidelines do not address insomnia or Ambien. The ODG states Zolpidem (Ambien) is approved for the short-term (usually two to six weeks) treatment of insomnia. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, they can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. The documentation indicates that the patient has been on Ambien. The ODG does not recommend this medication long term and there are no extenuating circumstances to continue this medication beyond the 2-6 week short term treatment. The request for Zolpidem 10mg is not medically necessary.

