

Case Number:	CM15-0104878		
Date Assigned:	06/09/2015	Date of Injury:	05/21/1992
Decision Date:	07/10/2015	UR Denial Date:	04/30/2015
Priority:	Standard	Application Received:	06/01/2015

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 51year old female who sustained an industrial injury on 05/21/1992. The injured worker was diagnosed with degenerative disc disease and displacement of lumbar intervertebral disc without myelopathy. Treatment to date includes chiropractic therapy, physical therapy, steroid injections, home exercise program and medications. According to the treating physician's progress report on March 26, 2015, the injured worker continues to experience low back, left neck and shoulder pain. The injured worker rates her pain level at 9/10 without medications and reduced to 5/10 with medications. Examination demonstrated diffuse focal tenderness over the L4-5 and L5-S1 segments with decreased range of motion and significant dyskinetic recovery from a forward flexion and limited painful lumbar extension with radiation into the left hip. A trigger point injection was administered with immediate improvement in symptoms. Current medications are listed as OxyContin, Norco, Soma, Paxil and Ambien. Treatment plan consists of medication and the current request for a retrospective request for trigger point injection (DOS: 3/26/2015) and medication renewal of Paxil and Ambien.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for trigger point injection (DOS: 3/26/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122.

Decision rationale: Retrospective request for trigger point injection (DOS: 3/26/15) is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that there should be documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain. The documentation does not reveal evidence of these findings therefore the retrospective request for a trigger point injection is not medically necessary.

Ambien CR 12.5mg #30, 3 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 (ODG), Insomnia treatment.

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

Decision rationale: Ambien CR 12.5mg #30, 3 refills is not medically necessary per the ODG guidelines. The MTUS Guidelines do not address insomnia or Ambien. The ODG states that Zolpidem (Ambien) is a prescription short-acting non-benzodiazepine hypnotic, which is recommended for short-term (7-10 days) treatment of insomnia. The ODG states that proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. The documentation does not indicate extenuating circumstances that necessitate this medication long term. The request for Ambien is not medically necessary.

Paxil 40mg #30, 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-14, 107.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SSRIs (selective serotonin reuptake inhibitors) Page(s): 107.

Decision rationale: Paxil 40mg #30, 3 refills is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that antidepressants are not recommended as a treatment for chronic pain, but SSRIs may have a role in treating secondary depression. The documentation does not indicate depression or a clear rationale for this medication or evidence of efficacy specifically related to Paxil. The continued use of this medication is not medically necessary.