

Case Number:	CM15-0130392		
Date Assigned:	07/16/2015	Date of Injury:	11/09/1998
Decision Date:	08/13/2015	UR Denial Date:	07/02/2015
Priority:	Standard	Application Received:	07/07/2015

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: Emergency 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 57-year-old male who sustained an industrial injury on 11/09/1998. The injured worker was diagnosed with chronic cervical facet joint pain, fibromyalgia and chronic low back pain. The injured worker is status post cervical fusion in 2000. Treatment to date has included diagnostic testing, cervical spine surgery, physical therapy, right C4, C5 and C6 dorsal median branch diagnostic block on March 6, 2015 and medications. According to the primary treating physician's progress report on June 16, 2015, the injured worker continues to experience neck and low back pain. Examination reported pain over the cervical facet joints with positive facet maneuver tests and paresthesias down his right arm. There was tenderness over the lumbar paraspinal regions noted. Current medications are listed as Percocet 7.5/325mg, Cymbalta, Prevacid, Ambien and Lidoderm patches. Treatment plan consists of continuing medication regimen, possible radiofrequency ablation and the current request for Percocet 7.5/325mg and Ambien.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 7.5/325mg four times daily #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75-93, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-79.

Decision rationale: Percocet is acetaminophen and Oxycodone, an opioid. Patient has chronically been on an opioid pain medication. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. Patient is noted to have been stable on Norco for months with appropriate documentation of the 4A's. The provider decided to switch to percocet due to denial of Norco. This is not an appropriate rationale for a switch in opioid medications. The provider has also never documented any attempt to wean patient from patient's chronic opioid regimen. As per guidelines, pt should be on as short course and as low dose regimen as possible. While patient has stable control of pain on prior norco regimen, the lack of attempt at decreasing opioid dose or frequency does not criteria. The ongoing opioid therapy does not meet criteria and rationale for switching opioids is not appropriate. Percocet is not medically necessary.

Ambien 10mg daily at bedtime #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

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), Insomnia Treatment).

Decision rationale: There are no specific sections in the MTUS chronic pain or ACOEM guidelines that relate to this topic. Ambien is a benzodiazepine agonist approved for insomnia. As per ODG guidelines, it recommends treatment of underlying cause of sleep disturbance and recommend short course of treatment. Long-term use may lead to dependency. Patient has been on Ambien for at least one month. There is no documentation of other conservative attempts at treatment of sleep disturbance or sleep studies. The prescription is excessive and not consistent with short-term use or attempts to wean patient off medication. The chronic use of Ambien is not medically appropriate and is not medically necessary.