

Case Number:	CM15-0166162		
Date Assigned:	09/03/2015	Date of Injury:	02/19/2003
Decision Date:	10/06/2015	UR Denial Date:	08/05/2015
Priority:	Standard	Application Received:	08/24/2015

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 44 year old male, who sustained an industrial injury on 02-19-2003. He has reported injury to the low back and right knee. The diagnoses have included intractable lumbar pain; status post lumbar spine surgery with retained hardware; intervertebral disc disorder; chronic failed back syndrome; chronic lumbosacral radiculopathy; status post right knee arthroscopy; right knee tendinitis-bursitis; and current tear of medial cartilage or meniscus of knee. Treatment to date has included medications, diagnostics, injections, physical therapy, and surgical intervention. Medications have included Percocet, Lidoderm Patch, Baclofen, Gabapentin, and Ambien. A progress report from the treating physician, dated 07-22-2015, documented a follow-up visit with the injured worker. The injured worker reported chronic pain in his lumbar spine with radiation of pain to the bilateral lower extremities; the pain level is 9 out of 10 in intensity on a numeric pain rating scale without medications, and 7 with medications; the pain is described as constant and burning; there is tingling; it is waking him up at night; it affects his quality of life; and he is currently having physical therapy. Objective findings included he is visibly uncomfortable, ambulating with antalgic gait, using one-pointed cane for the balance; he is sitting with difficulty; spasm and tenderness is observed over the paravertebral muscles of the lumbar spine; decreased range of motion on flexion and extension; dysesthesia is noted in L4, L5, and S1 dermatomal distributions bilaterally; and he is scheduled for the spinal cord stimulator trial at the beginning of August 2015. The treatment plan has included the request for Percocet 10-325mg #150; and Ambien 10mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, long-term assessment, Opioids for chronic pain.

Decision rationale: Norco is acetaminophen and hydrocodone, 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. Documentation fails criteria. Last 5 months of records show continued severe pain with minimal improvement in pain. Provider has continued to fail to document objective functional improvement despite a prior Utilization denial and independent medical review appeal. The lack of benefit from this medication by provider's documentation does not support continued opioid therapy. Percocet is not medically necessary.

Ambien 10mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Zolpidem (Ambien).

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 chronically. There is no documentation of other conservative attempts at treatment of sleep disturbance or sleep studies. There is not documentation of any improvement in claimed sleep issues on this medication. The chronic use of Ambien is not medically appropriate and is not medically necessary.