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| Case Number: | CM15-0166316 | | |
| Date Assigned: | 09/04/2015 | Date of Injury: | 04/08/2002 |
| Decision Date: | 10/07/2015 | UR Denial Date: | 08/07/2015 |
| 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 56 year old male, who sustained an industrial injury on April 8, 2002. Treatment to date has included left knee arthroscopic surgery, shoulder arthroscopic surgery, NSAIDS, and pain medications. Currently, the injured worker complains of pain in his neck, low back, bilateral shoulders and bilateral knees. He describes the pain as sharp, stabbing pain with associated stiffness, weakness, numbness, paresthesia, instability and generalized discomfort. He reports a good but partial response from his medications. On physical examination, the injured worker exhibited a decreased range of motion of the cervical spine, the lumbar spine, and the bilateral shoulders in all planes. He had positive drop tests bilaterally. The injured worker had reduced strength in the distribution of the femoral nerves and the suprascapular nerves bilaterally. He had reduced range of motion of the bilateral knees with tenderness to palpation in the bilateral medial aspect. The diagnoses associated with the request include bilateral knee internal derangement with medial meniscus tears, status post left knee arthroscopic surgery, bilateral rotator cuff syndrome, status post arthroscopic surgery of the shoulder, and chronic pain syndrome. The treatment plan includes Norco for generalized discomfort, Anaprox for inflammation, Soma, Prilosec and Ambien.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 mg Qty 120: 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 for chronic pain, Opioids, long-term assessment.

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. There is no documentation of assessment for objective improvement in pain or function. While there is urine drug screening, there is no assessment of abuse or side effects. The lack of efficacy or documentation of long term plan does not meet criteria for recommendation. Norco is not medically necessary.

Carisoprodol 350 mg Qty 90: 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): Carisoprodol (Soma).

Decision rationale: As per MTUS Chronic pain guidelines, Carisoprodol or Soma is a muscle relaxant and is not recommended. There is a high risk of side effects and can lead to dependency requiring weaning. Carisoprodol has a high risk of abuse and can lead to symptoms similar to intoxication and euphoria. Documentation does not provide any rational justification for continuing this medically inappropriate medication. Use of Carisoprodol, a potentially addictive, dangerous and not-recommended medication, is not medically necessary.

Zolpidem ER (extended release) 12.5 mg Qty 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-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 is 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. Patient has been on Ambien chronically. There is no documentation of other conservative attempts at treatment of sleep disturbance or sleep studies. The chronic use of Ambien is not medically appropriate and is not medically necessary.

