

Case Number:	CM15-0182276		
Date Assigned:	09/23/2015	Date of Injury:	08/27/2008
Decision Date:	11/02/2015	UR Denial Date:	08/20/2015
Priority:	Standard	Application Received:	09/16/2015

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: Arizona, California
 Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 51 year old male, who sustained an industrial injury on 08-27-2008. The injured worker was diagnosed as having chronic back pain with minimal bilateral extremity radiculopathy. On medical records dated 07-22-2015, 06-17-2015 and 06-03-2015, subjective complaints were noted as ongoing low back pain with radicular symptoms into his lower extremities bilaterally. Objective findings were noted as tenderness to palpation as well as spasms bilaterally about the paralumbar musculature. Active range of motion of thoracolumbar spine was severely limited due to pain. The injured worker was noted to be permanent and stationary. Pain level with medication on visual analogue scale was noted as 41 and without medication 82. No mention of sleep disturbance was noted. Treatment to date include: pain management consultations, surgical intervention, physical therapy, medication and trigger point injections. Current medication was listed Gabapentin, Diclofenac, Vicoprofen and Zanaflex. The Utilization Review (UR) was dated 08-20-2015. A request for retrospective Vicoprofen 7.5-200mg #180 (DOS 07-22-2015) and Ambien 10mg #30 with 3 refills was submitted. The UR submitted for this medical review indicated that the request for retrospective Vicoprofen 7.5-200mg #180 (DOS 07-22-2015) was modified to #60 and Ambien 10mg #30 with 3 refills was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Vicoprofen 7.5/200mg, #180 (DOS: 07/22/2015): 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): NSAIDs (non-steroidal anti-inflammatory drugs), Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: Hydrocodone is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated as 1st line therapy for neuropathic pain, and chronic back pain . It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. According to the guidelines, NSAIDs are recommended as a second-line treatment after acetaminophen. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain. NSAIDs are recommended as an option for short-term symptomatic relief. In this case, the claimant had been on NSAIDs for several. There was no indication of Tylenol failure. Long-term NSAID use has renal and GI risks. Vicoprofen contains Ibuprofen and Hydrocodone. The claimant had been on NSAIDS in addition to the Ibuprofen for several months. Pain reduction attributed to the Vicoprofen is unknown. Long-term use is not recommended. The continued use of Vicoprofen is not medically necessary.

Ambien 10mg, #30 with 3 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter and pg 64.

Decision rationale: The MTUS guidelines do not comment on insomnia. According to the ODG guidelines, recommend that treatment be based on the etiology, with the medications. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. Zolpidem is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). In this case, the claimant had used the medication for several months. The etiology of sleep disturbance was not defined or further evaluated. Continued use of Zolpidem (Ambien) with 3 more months of refills is not medically necessary.