

Case Number:	CM15-0196081		
Date Assigned:	10/09/2015	Date of Injury:	03/22/2009
Decision Date:	11/18/2015	UR Denial Date:	09/28/2015
Priority:	Standard	Application Received:	10/06/2015

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:

The injured worker is a 41 year old female, who sustained an industrial injury on March 22, 2009, incurring low back injuries. She was diagnosed with lumbar disc disease with disc bulging and lumbar fracture. Treatment included pain medications, anti-inflammatory drugs, sleep aides, antidepressants, diagnostic imaging and activity restrictions. Currently the injured worker complained of persistent low back pain radiating into the left sacroiliac joint. She rated the pain 7 out of 10 on a pain scale from 0 to 10 with medications. The continuous chronic pain interfered with her activities of daily living included self-care and household chores and climbing stairs. She noted limited range of motion with an altered gait. Walking and standing for long periods of time aggravated the low back pain. She noted sleeping difficulties with the ongoing low back and hip pain. The treatment plan that was requested for authorization on October 6, 2015, included prescriptions for Ambien CR 12.5 mg, #30 and Percocet 10-325mg, #75 and a request for a liver panel test. On September 28, 2015, a request for prescriptions for Ambien and Percocet and a request for a liver panel test were denied by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien CR 12.5mg, #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 (ODG) Ambien (Zolpidem).

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. Prior to that, the claimant was on other sleep medications dating back to 2007 (Lunesta) The etiology of sleep disturbance was not recently addressed and failure in behavioral intervention is unknown. Continued use of Zolpidem (Ambien) is not medically necessary.

Percocet 10/325mg, #75: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

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

Decision rationale: Percocet 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. In this case, the claimant had been on Norco for over a year. Pain relief in combination with Ibuprofen was noted to be 50%. No one opioid is superior to another. There was no mention of Tylenol, Tricyclic or weaning failure. Percocet was added to Norco without justification on 8/22/15. The continued use of Percocet is not medically necessary.

Liver panel test: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk, NSAIDs, specific drug list & adverse effects, Opioids, long-term assessment, Opioids, screening for risk of addiction (tests). Decision based on Non-MTUS Citation ISRN Gastroenterol. 2011; 2011: 592404 Published online 2011

Aug 28, Obesity, Visceral Fat, and NAFLD: Querying the Role of Adipokines in the Progression of Nonalcoholic Fatty Liver Disease, M. S. Mirza.

Decision rationale: According to the guidelines, hepatic function should be monitored in those with liver disease and using NSAIDS or opioids. In this case, the claimant was on opioids and NSAIDS. The claimant had morbid obesity and was scheduled to go for a weight loss program and possible bariatric surgery. Such patients are at risk for steatohepatitis and the evaluation of liver function tests is appropriate. The request is medically necessary.