

Case Number:	CM15-0206726		
Date Assigned:	10/23/2015	Date of Injury:	02/27/2007
Decision Date:	12/08/2015	UR Denial Date:	09/30/2015
Priority:	Standard	Application Received:	10/21/2015

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 61-year-old female who sustained an industrial injury on 2-27-07. A review of the medical records indicates that the worker is undergoing treatment for lumbar disc degeneration, chronic pain-other, lumbar facet arthropathy, lumbar post laminectomy syndrome, lumbar radiculopathy, lumbar spinal stenosis, bilateral pain, diabetes mellitus type 2 with hyperglycemia, and hypertension. Subjective complaints (9-15-15) include thoracic back pain, low back pain that radiates down the bilateral lower extremities; right greater than left, and to the buttocks, bilateral hips, and thighs, accompanied by numbness intermittently in the right lower extremity to the level of the thigh. Pain is reported to be aggravated by activity, standing and walking. Pain is rated at 6 out of 10 with medications and 8 out of 10 without medications. Objective findings (9-15-15) include a slow antalgic gait (uses a cane), tenderness to palpation at bilateral paravertebral L4-S1 levels, "moderately to severely" limited lumbar spine range of motion, increased pain with flexion and extension, decreased sensitivity to touch along the L4-S1 dermatome in bilateral lower extremities, and a positive seated straight leg raise at 60 degrees bilaterally. Work status was noted as not currently working. The insomnia severity index was administered 3-11-14 resulting in a total score of 20, which is noted as moderate severity clinical insomnia. It is noted the "5-As" method for chronic pain management assessment have been considered and there is a pain contract on file. The treatment plan includes Norco, Voltaren 1% Gel, Ambien, Ibuprofen, and Tylenol #3. Previous treatment includes transforaminal epidural steroid injection bilateral L4-S1 (8-18-15) with reported 20-50% overall improvement, facet radiofrequency rhizotomy bilateral L4-S1 (with reported limited response), and medication. The requested treatment of Norco 10-325mg #90 and Ambien 10mg #30 was on 9-30-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, 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. Documentation fails to show any significant benefit from pain meds, with persistent severe pain. There is no documentation of any improvement in functional status. There is no documentation of long-term plan with a noted attempt to wean from opioids or changing therapy. Notes also state that patient is receiving Tylenol #3 (contains codeine) from another provider, which is a clear violation of MTUS guidelines recommendation that patient, receive opioids only from a single provider. Documentation fails to support continued use of norco. 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 (ODG), Pain (Chronic): Zolpidem (Ambien) (2015).

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, it appears for years. 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. While patient has noted insomnia, the chronic use of Ambien is not medically appropriate and is not medically necessary.