

Case Number:	CM15-0020075		
Date Assigned:	02/09/2015	Date of Injury:	10/16/2006
Decision Date:	04/01/2015	UR Denial Date:	01/14/2015
Priority:	Standard	Application Received:	02/03/2015

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, Arizona
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 39-year-old male who reported an injury on 10/16/2006. The mechanism of injury was not specifically stated. The current diagnoses include lumbar postlaminectomy syndrome; lumbar radiculopathy; status post lumbar fusion; depression; medication related dyspepsia; chronic pain; and vitamin D deficiency. The injured worker presented on 12/19/2014 for a followup evaluation with complaints of persistent neck pain, low back pain, and radiation into the upper and lower extremities. The injured worker also reported bilateral hip pain, ongoing headaches, and insomnia. Upon examination, there was tenderness to palpation over the spinal vertebral area from L4-S1, spasm noted at L3-5; moderately limited lumbar range of motion secondary to pain; decreased strength in the extensor muscles along the L4-S1 dermatome in the bilateral lower extremities; and negative straight leg raise bilaterally. There was tenderness to palpation noted at the bilateral hips. Recommendations at that time included continuation of the home exercise program and continuation of the current medication regimen of hydrocodone/APAP, ibuprofen, tramadol ER, vitamin D, Ambien, and ibuprofen 10% ointment. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Enovarx-Ibuprofen 10 percent kit #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second line option after acetaminophen. There was no indication that this injured worker was actively utilizing this medication. The medical necessity has not been established. There is no mention of a contraindication to traditional oral NSAIDs. There is also no frequency listed in the request. As such, the request is not medically appropriate.

Vitamin D2000 Units 2 tab QD #100: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine, 2nd Edition and Official Disability Guidelines-Treatment for Workers' Compensation, Online Edition.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Vitamin D.

Decision rationale: The Official Disability Guidelines do not recommend vitamin D for the treatment of chronic pain. Although it is noted that the injured worker maintains a diagnosis of vitamin D deficiency, there is no documentation of any recent laboratory studies documenting evidence of a vitamin D deficiency. The medical necessity for the requested medication has not been established. As such, the request is not medically appropriate.

Zolpidem 10mg QHS #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine, 2nd Edition; Official Disability Guidelines-Treatment for Workers' Compensation, Online Edition, Chapter: Pain (Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Chapter, Insomnia Treatment.

Decision rationale: The Official Disability Guidelines recommend insomnia treatment based on etiology. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. There was no documentation of a failure to respond to non-pharmacologic treatment for insomnia prior to the initiation of a prescription product.

Additionally, the Official Disability Guidelines do not recommend long term use of this medication. Given the above, the request is not medically appropriate.