

Case Number:	CM15-0037035		
Date Assigned:	03/05/2015	Date of Injury:	03/30/2010
Decision Date:	04/09/2015	UR Denial Date:	02/03/2015
Priority:	Standard	Application Received:	02/27/2015

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: Connecticut, California, Virginia
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 38-year-old female with an industrial injury dated 03/30/2010, which resulted in a low back injury. Diagnoses include displacement of lumbar intervertebral disc without myelopathy, neck pain, and lumbar post laminectomy syndrome. No recent diagnostic testing was submitted or discussed. Previous treatments have included conservative measures, medications, aquatic therapy, lumbar fusion with revision, and physical therapy. A progress note dated 01/23/2015, reports constant low back pain, neck pain, and residual right lower extremity weakness with right foot drop. The objective examination revealed an antalgic gait, AFO to the right lower extremity, muscle aches and weakness, joint pain and swelling of the right foot. The treating physician is requesting Medrol Dosepack and Ambien which were denied by the utilization review. On 02/03/2015, Utilization Review non-certified prescriptions for Medrol Dosepack 4mg #21, and Ambien 5mg #60, citing the ODG guidelines. On 02/27/2015, the injured worker submitted an application for IMR for review of Medrol Dosepack 4mg #21, and Ambien 5mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medrol Dosepack 4mg Qty 21: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines, Pain, Oral corticosteroids.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back.

Decision rationale: According to the MTUS ACOEM Guidelines and the ODG Guidelines, oral corticosteroids are not recommended as a treatment modality in cases of chronic pain management. The provided records do not indicate any remarkable factors that may substantiate the request; according to the note dated 1/23/15, the patient is currently working at full duty status without restrictions and continuing home exercises. The physical exam is brief and lacks detail, but there is no indication of severe deficits/acute radiculopathy or concerns that warrant treatment outside of that supported by the guidelines based on the provided documentation. The assessment and plan from the note dated 1/23/15 indicate that the patient would like a dosepack in case she experiences an acute exacerbation, however, there are no current clinical indications for treatment with corticosteroids, and therefore the request cannot be considered medically necessary.

Ambien 5mg Qty 60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines.

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

Decision rationale: According to the ODG guidelines, Ambien is indicated for short-term treatment (two to six weeks) of insomnia and is not considered appropriate in for long-term sleep concerns. There are other medications and non-pharmacologic modalities that should be considered as long-term treatments for insomnia. Per the ODG Guidelines for Insomnia, Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Other modalities for sleep improvement should be considered, along with possible other medications that are more appropriate for long-term treatment (it is noted that the patient has previously failed trazodone, but alternatives to long-term sedative-hypnotics should be considered). If continued treatment with Ambien is required, more detailed documentation of failed sleep treatments and reasoning as to why other pharmacotherapy is not attempted should be provided, along with sleep study data. The quantity of 60 tablets indicates an intent to treat in excess of six weeks, and without a more detailed plan for follow up and reevaluation, the request cannot be considered medically necessary based on the provided documents.