

Case Number:	CM15-0051386		
Date Assigned:	03/24/2015	Date of Injury:	09/20/2004
Decision Date:	05/12/2015	UR Denial Date:	02/20/2015
Priority:	Standard	Application Received:	03/18/2015

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: 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 sustained an industrial injury on 9/20/2004. Diagnoses include lumbar degenerative disc disease, low back pain, lumbar facet syndrome, and lumbar radiculopathy. Treatment to date has included lumbar discogram at L3-4, L4-5 and L5-S1, transforaminal epidural steroid injections (TESI), medial branch block, medications and diagnostics. Per the Primary Treating Physician's Progress Report dated 1/29/2015, the injured worker reported pain rated as 5 on a scale of 1-10. He does not report any change in location of pain. Physical examination revealed restricted range of motion of the lumbar spine due to pain. There was paravertebral muscle tenderness to palpation with a tight muscle band noted bilaterally. Lumbar facet loading is positive on both sides. Straight leg raise test is positive on the right sitting at 10 degrees. There was tenderness over the sacroiliac spine. The plan of care included TESI and medications and authorization was requested for Oxycontin 20mg #60, Norco 10/325mg #180 and Ambien 10mg #15

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin 20 mg Qty 60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: The patient has a date of injury of 09/20/04 and presents with increased back pain radiating from the low back down the right leg. The Request for Authorization is dated 02/10/15. The current request is for OXYCONTIN 20MG #60. For chronic opiate use, the MTUS guidelines pages 88 and 89 states, "Pain should be assessed at each visit and function should be measured at 6-month intervals using a numerical scale or validated instrument." The MTUS page 78 also requires documentation of the 4 A's, which includes analgesia, ADLs, adverse side effects, and aberrant behavior. MTUS also requires pain assessment or outcome measures that include current pain, average pain, least pain; intensity of pain after taking the opioid, time it takes for medication to work, and duration of pain relief. The patient has been utilizing this medication since at least 02/28/14. The patient reports that without Oxycontin "the pain would be poorly controlled and he would be more sedentary." Progress reports continually provide a before and after pain scale, which denotes a decrease in pain with taking medications. The patient reports that medications are "working well" and with the use of medications he is able to exercise, walk longer distances, cook, clean and do laundry. CURES was checked on 07/15/14 and was appropriate, routine drug screens are administered to monitor compliance and the patient reports no side effects with medications. In this case, the treating physician has provided adequate documentation including the 4A's as requirement by MTUS for opiate management. The request is medically necessary.

Norco 10/325 mg Qty 180: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 76-78, 88-89.

Decision rationale: The patient has a date of injury of 09/20/04 and presents with increased back pain radiating from the low back down the right leg. The Request for Authorization is dated 02/10/15. The current request is for NORCO 10/325MG QTY. 180. For chronic opiate use, the MTUS guidelines pages 88 and 89 states, "Pain should be assessed at each visit and function should be measured at 6-month intervals using a numerical scale or validated instrument." The MTUS page 78 also requires documentation of the 4 A's, which includes analgesia, ADLs, adverse side effects, and aberrant behavior. MTUS also requires pain assessment or outcome measures that include current pain, average pain, least pain; intensity of pain after taking the opioid, time it takes for medication to work, and duration of pain relief. The patient has been utilizing this medication since at least 02/28/14. The patient reported that, "Norco starts working within 30 mins and lasts up to 3-4 hours to reduce flared pain from activities throughout the day." Progress reports continually provide a before and after pain scale, which denotes a decrease in pain with taking medications. The patient reported that medications

are "working well" and with the use of medications he is able to exercise, walk longer distances, cook, clean and do laundry. CURES was checked on 07/15/14 and was appropriate, routine drug screens are administered to monitor compliance and the patient reports no side effects with medications. In this case, the treating physician has provided adequate documentation including the 4A's as requirement by MTUS for opiate management. The request is medically necessary.

Ambien 10 mg Qty 15 with 1 refill: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness and Stress Chapter Regarding Zolpidem/Ambien.

Decision rationale: The patient has a date of injury of 09/20/04 and presents with increased back pain radiating from the low back down the right leg. The Request for Authorization is dated 02/10/15. The current request is for Ambien 10mg QTY. 15 with 1 refill. The ACOEM and MTUS Guidelines do not address Ambien; however, the ODG Guidelines under the mental illness and stress chapter regarding Zolpidem/Ambien states, "Zolpidem, Ambien generic available Ambien CR, is indicated for short-term treatment of insomnia with difficulty of onset (7-10 days)." In this case, review of the medical file indicates the patient has been utilizing Ambien as early as 02/28/14 and ODG only supports short-term use of this medication. The requested Ambien is not medically necessary.