MAXIMUS Federal Services

Case Number:	CM15-0080798		
Date Assigned:	05/05/2015	Date of Injury:	08/01/2011
Decision Date:	06/03/2015	UR Denial Date:	04/15/2015
Priority:	Standard	Application Received:	04/28/2015

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 45-year-old female, who sustained an industrial/work injury on 8/1/11. She reported initial complaints of neck pain that radiated to the upper extremities with numbness in the hands. The injured worker was diagnosed as having cervicalgia and headaches, right sacroiliac joint pain. Treatment to date has included medication and right sided medial branch blocks. Currently, the injured worker complains of neck pain, upper and lower back pain. Recent medial branch block gave some relief. Per the primary physician's progress report (PR-2) on 4/9/15, examination revealed tenderness to right cervical facet, tenderness with extension and rotation, (R>L), tender right sacroiliac joint, and positive Faber's test on right. The requested treatments include Ambien and Percocet.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10mg tab #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 Chapter, Zolpidem (Ambien).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG- pain chapter- insomnia and pg 64.

Decision rationale: The MTUS guidelines do not comment on insomnia. According to the ODG guidelines, insomnia medications 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 (Ambien) 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. The etiology of sleep disturbance was not defined or further evaluated nor failure in behavioral interventions noted. Continued use of Ambien is not medically necessary.

Percocet 10/325mg tab #200: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percocet (Oxycodone & Acetaminophen), On-Going Management, Opioids, Weaning of Medications Page(s): 102, 81, 79-80, 131. Decision based on Non-MTUS Citation Opioid Treatment Guidelines from the American Pain Society and American Academy of Pain Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 82-92.

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 Percoset in combination with MSContin for several months. The combined dose of opiods exceeds the 120 mg of Morphine equivalent recommended per day. There was no mention of Tylenol failure. Continues use of Percocet is not medically necessary.