

Case Number:	CM15-0089691		
Date Assigned:	05/14/2015	Date of Injury:	10/30/2010
Decision Date:	08/11/2015	UR Denial Date:	05/05/2015
Priority:	Standard	Application Received:	05/11/2015

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 (IW) is a 66-year-old female who sustained an industrial injury on 10/30/2010. The mechanism of injury and initial report of injury are not found in the records reviewed. The injured worker was diagnosed as having neural encroachment L4-5 and L4-S1 with radiculopathy, facet osteoarthroplasty L4-5, and L5-S1; Right hip osteoarthropathy and tensor facia lata tendinitis; and left shoulder pain. Treatment to date has included physical therapy, a home exercise program, medications and chiropractic care. Currently, the injured worker complains of low back pain with right greater than left lower extremity symptoms rated 7 on a scale of 1-10. The low back has diminished range of motion in all planes. There is tenderness at the lumbar spine with lumbo paraspinal muscle spasm that has diminished since prior exam. She has right hip pain that with motion limited by pain that is rated 5 on a scale of 1-10, and right shoulder pain that is rated 5 on a scale of 1-10. The range of motion is limited. Both the right hip and right shoulder exam are unchanged since the exam of the month prior. Medications include Tramadol, Cyclobenzaprine, Gabapentin, and Hydrocodone. The mechanism of injury and initial report of injury are not found in the records reviewed.

1. Hydrocodone 10/325mg #902. Ambien 10mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-80, 88.

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

Decision rationale: Hydrocodone 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 Hydrocodone months along with Tramadol an NSAID with little improvement in pain or function. Continued and chronic use of Hydrocodone is 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, Pain, Zolpidem (Ambien).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter and insomnia- 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 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. There was no mention of failure of behavioral interventions. Continued use of Zolpidem is not medically necessary.