

Case Number:	CM14-0134889		
Date Assigned:	08/27/2014	Date of Injury:	09/10/2009
Decision Date:	10/30/2014	UR Denial Date:	07/21/2014
Priority:	Standard	Application Received:	08/21/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 40-year-old male who reported an injury on 09/10/2009. The mechanism of injury was not stated. The current diagnoses include herniated nucleus pulposus of the lumbar spine and lumbar radiculopathy. Previous conservative treatment was noted to include medications, physical therapy, injections, chiropractic treatment, and acupuncture. The injured worker was evaluated on 08/06/2014 with complaints of persistent neck pain. The current medication regimen included Norco, Ambien, Docuprene, and Gabapentin. The physical examination revealed an antalgic gait, tenderness to palpation over the cervical and lumbar paraspinal muscles bilaterally, limited lumbar and cervical range of motion, decreased sensation in the right C7 dermatome, decreased sensation in the left L4-S1 dermatomes, and motor weakness in the bilateral upper and lower extremities. The treatment recommendations at that time included continuation of the current medication regimen. A Request for Authorization form was then submitted on 08/06/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/APAP 10/325 mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has continuously utilized this medication since 03/2014. There was no documentation of objective functional improvement. There was also no frequency listed in the request. As such, the request is not medically appropriate.

Ambien 10 mg #30: Upheld

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

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, Insomnia Treatment.

Decision rationale: The Official Disability Guidelines state insomnia is treatment based on etiology. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. The injured worker does not maintain a diagnosis of insomnia or sleep disorder. There was also no frequency listed in the request. As such, the request is not medically appropriate.