

Case Number:	CM14-0149458		
Date Assigned:	09/18/2014	Date of Injury:	10/16/2000
Decision Date:	11/19/2014	UR Denial Date:	08/19/2014
Priority:	Standard	Application Received:	09/15/2014

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 Anesthesiologist, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 43-year-old female who reported an injury on 10/16/2000. The mechanism of injury was not submitted for clinical review. The diagnoses included shoulder impingement, status post arthroscopic surgery, cervical disc protrusion at C5-6 and C6-7, status post cervical epidural injection, depression, and occipital neuralgia. Previous treatments included medication, surgery, and epidural steroid injections. Surgeries included right shoulder impingement and post arthroscopic surgery. In the clinical note dated 04/23/2014 it was reported the injured worker complained of right shoulder pain. Upon physical examination, the provider noted the injured worker to have decreased cervical range of motion. Tenderness to palpation was noted along the left neck. Bilateral trapezii were noted to be tight. Tenderness to palpation was also noted in the right occipital nerve. The medication regimen included Norco, Neurontin, Zanaflex, Ambien, and Motrin. The provider requested Ambien and hydrocodone/acetaminophen. However, a rationale was not submitted for clinical review. The Request for Authorization was not submitted for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

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/Treatment in Workers Compensation/Pain

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

Decision rationale: The Official Disability Guidelines indicate zolpidem is appropriate for short term treatment of insomnia, and approved for short term use, usually 2 to 6 weeks for treatment of insomnia. Clinical documentation submitted failed to provide the efficacy of the medication as evidence by significant functional improvement. The request submitted failed to provide the frequency of the medication. The clinical documentation does not indicate the injured worker was treated for insomnia. Additionally, the injured worker has been utilizing the medication since at least 2014, which exceeds the guidelines recommendation of short term use of 2 to 6 weeks. Therefore, the request is not medically necessary.

Hydrocodone 10mg-Acetaminophen 325mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 77-78.

Decision rationale: The request for hydrocodone 10mg-acetaminophen 325mg #90 is not medically necessary. California MTUS guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction or poor pain control. There is a lack of documentation indicating the efficacy of the medication as evidence by significant functional improvement. The request submitted failed to provide the frequency of medication. Additionally, the provider failed to document an adequate and complete pain assessment within the documentation. Therefore, the request is not medically necessary.