

Case Number:	CM14-0181944		
Date Assigned:	11/05/2014	Date of Injury:	12/06/2004
Decision Date:	12/15/2014	UR Denial Date:	10/23/2014
Priority:	Standard	Application Received:	11/03/2014

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 & Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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 patient is a 52-year-old male with an injury date of 12/06/2004. According to the 07/11/2014 progress report, the patient complains of having lower back ache. She rates her pain at a 6/10 with medications and a 7/10 without medications. He has a poor quality of sleep and states that medications are working well. In regards to lumbar spine, there are trigger points with radiating pain and twitch response on palpation at lumbar paraspinal muscles on the right. Upon sensory examination, there is a decreased light touch sensation to the right lateral thigh and calf. The 09/04/2014 report also states that on palpation, paravertebral muscle spasm, tenderness, and tight muscle band are noted on both sides of the lumbar spine. The 10/09/2014 report states that the patient has been having an increased tremor in his bilateral hands and in his legs as well. The tremor is worse in his right leg. The patient's diagnoses include the following: 1.Spinal/lumbar DDD.2.Disk disorder lumbar.3.Low back pain.4.Depressive disorder NEC.5.Spasm of muscle.The utilization review determination being challenged is dated 10/23/2014. Treatment reports were provided from 05/15/2014 - 10/09/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 15mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation ODG

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

Decision rationale: MTUS Guidelines pages 88 and 89 states, "The patient should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4A's (analgesia, ADLs, adverse side effects, and adverse behavior) as well as "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. All 4 progress reports provided indicate the same statement about how oxycodone has helped the patient. No urine toxicology is provided nor are any other chronic opiate management issues such as CURES report, pain contacts, etc., provided. No outcome measures are provided either as required by MTUS. Recommendation is for denial.

Ambien Cr 12.5mg, #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress chapter, Insomnia treatment

Decision rationale: According to the 10/09/2014 report, the patient complains of having lower back ache. The request is for Ambien CR 12.5 mg #30. The patient has been taking Ambien as early as 05/15/2014. The MTUS and ACOEM Guidelines do not address the Ambien. However, ODG Guidelines states that Ambien is indicated for short-term treatment of insomnia with difficulty of sleep onset, 7 to 10 days. ODG Guidelines does not recommend long-term use of this medication. The patient has been taking Ambien as early as 05/15/2014 which exceeds ODG Guidelines. Recommendation is for denial.