MAXIMUS Federal Services

Case Number:	CM15-0011749		
Date Assigned:	01/29/2015	Date of Injury:	10/28/2010
Decision Date:	03/27/2015	UR Denial Date:	01/14/2015
Priority:	Standard	Application Received:	01/20/2015

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: New York, West Virginia, Pennsylvania
Certification(s)/Specialty: Emergency Medicine

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 was a 61 year old male, who sustained an industrial injury, October 28, 2010. The injured worker was diagnosed with post laminectomy syndrome, status post decompression from L2 to L in August 2012, spinal stenosis from L2-L5, left sided foraminal stenosis at L3-L4 and L4-L5, disc height virtually gone L2-L3, depression, anxiety and chronic pain. The injured worker previously received the following treatments a MRI of the lumbar spine January 8, 2015, physical therapy, pain medication, anti-depressants and sleep aides. The injured workers chief complaint was on going low back pain with left leg pain. The injured worker was having increased pain in the low back with left leg pain. The injured worker had positive straight leg raise on the left side. The injured worker had sensory changes in the anterolateral thigh and pretibial area. On December 24, 2014, the primary treating physician requested prescriptions for Percocet 10/325mg #150 and Ambien 5mg #30. On January 14, 2015, the utilization review denied authorization for prescriptions for Percocet 10/325mg #150 and Ambien 5mg #30. The utilization Reviewer referenced MTUS and ODG guidelines for the decision.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325 mg #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80, 92, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS 2009;9792, 24.2 Page(s): 78-80, 92, 124.

Decision rationale: Although the documentation did specify a reduction in pain level and increase in functionality, the inappropriate use of medications (evidenced by a drug screen positive for amphetamine and alcohol) indicated issues of compliance. Thus a tapering of Percocet 10/325 mg is recommended. The requested treatment was not necessary and appropriate.

Ambien 5 mg #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), Ambien

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS 2009; 9792, 24.2 Page(s): 78-80, 92,124.

Decision rationale: Ambien is approved for short term treatment of insomnia. Ambien is not recommended for long-term use due to a variety of serious side effects. Since the patient has been taking Ambien since 2010, a reduction in the number of Ambien 5 mg from #30 to #15 is recommended. The requested treatment was not necessary and appropriate.