

Case Number:	CM15-0121011		
Date Assigned:	07/01/2015	Date of Injury:	01/10/2005
Decision Date:	07/30/2015	UR Denial Date:	06/11/2015
Priority:	Standard	Application Received:	06/23/2015

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: North Carolina

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 is a 51-year-old female who sustained an industrial injury on 01/10/2005. Mechanism of injury was cumulative. Diagnoses include lumbar disc injury with facet arthralgia, cervical disc injury, cervical facet arthralgia and right sacroiliac arthralgia. Treatment to date has included diagnostic studies, medications, chiropractic sessions, S1 joint injections, transforaminal epidural blocks, and physical therapy. Her medications include Ambien, Vicodin, and Topamax, and Gabapentin with be discontinued. Magnetic Resonance Imaging of the lumbar spine done on 11/24/2015 showed two areas of lumbar herniated nucleus pulposus, multiple areas of degenerative disc changes, ventral L3 and L4 annular tear. The injured worker continues to work full duty. A physician progress note dated 05/27/2015 documents the injured worker complains of low back pain and pain into the right lower extremity. She rates her pain as 8-9 out of 10 in severity. She also has neck pain that she rates as 8 out of 10 on the pain scale. Her lower extremity pain has been more prominent. She is having trouble sleeping even with Gabapentin. Vicodin helps with her low back pain and she rates her pain as 3 out of 10 with the use of Vicodin. On examination the cervical pain range of motion is restricted with moderate pain on the right and light pain on the left. At left C2-C3, and right C3-C5 levels have flexion, rotation and side bending strain with paraspinal spasms. The lumbar spine has moderate pain over the right more than the left at L4 to S1 levels with flexion, rotation and side bending strain. There is moderate pain over the right sacroiliac joint and right greater trochanteric bursa region. Bilateral flip test is 90 degrees with pain referring to the right knee. Lumbar range of motion is restricted with slight pain to the right side. Treatment requested is for Ambien 5mg #30, lumbar traction, and Vicodin 10/300mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar traction: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301, Chronic Pain Treatment Guidelines Page(s): 16-21, 78-81, 86. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back complaints, traction.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: The ACOEM chapter on low back pain states: Traction has not been proved effective for lasting relief in treating low back pain. Because evidence is insufficient to support using vertebral axial decompression for treating low back injuries, it is not recommended. The requested service is not recommended per the ACOEM in the treatment of low back pain and therefore not certified. Therefore, the requested treatment is not medically necessary.

Ambien 5mg #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), pain chapter, Ambien.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, insomnia.

Decision rationale: The California MTUS and the ACOEM do not specifically address this medication. Per the official disability guidelines recommend pharmacological agents for insomnia only is used after careful evaluation of potential causes of sleep disturbance. Primary insomnia is usually addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. Pharmacological treatment consists of four main categories: Benzodiazepines, Non-benzodiazepines, Melatonin and melatonin receptor agonists and over the counter medications. Sedating antidepressants have also been used to treat insomnia however there is less evidence to support their use for insomnia, but they may be an option in patients with coexisting depression. The patient does not have the diagnosis of primary insomnia or depression. There is no provided clinical documentation of failure of sleep hygiene measures/counseling. Therefore the request is not certified. Therefore, the requested treatment is not medically necessary.

Vicodin 10/300mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81, 86.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 76-84.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to non-opioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids (a) If the patient has returned to work; (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox- AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is documented significant improvement in VAS scores for significant periods of time. There are no objective measurements of improvement in function. Therefore all criteria for the ongoing use of opioids have not been met and the request is not certified. Therefore, the requested treatment is not medically necessary.