

<b>Case Number:</b>	CM13-0033412		
<b>Date Assigned:</b>	12/06/2013	<b>Date of Injury:</b>	11/12/2001
<b>Decision Date:</b>	01/22/2014	<b>UR Denial Date:</b>	09/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/09/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in Oklahoma and Texas. 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 physician 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 65-year-old female who reported an injury on 11/12/2001. The mechanism of injury was not provided for review. The patient underwent several cervical interventions to include multiple cervical fusion surgeries, and wrist surgery. The patient also has significant complaints of low back pain radiating into the bilateral lower extremities. The patient has been treated with surgical intervention, medications, injections, and physical therapy. The patient does have a history of disturbed sleep patterns related to chronic pain complaints. The patient's most recent clinical evaluation revealed that the right shoulder was moderately tender to palpation with restricted range of motion described as 90 degrees in abduction with weakness of the right rotator cuff. Physical findings of the cervical spine revealed tenderness to palpation along the trapezius musculature with restricted range of motion described as 10 degrees in flexion, 10 degrees in extension, 30 degrees in right and left lateral bending, and 40 to 50 degrees in left to right rotation. The patient's diagnoses included brachial neuritis or radiculitis, cervical radiculitis, radicular syndrome, mixed anxiety and depressive mood disorder, and tenosynovitis of the hand and wrist. The patient's treatment plan included continuation of medications and physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien CR 12.5mg, #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Zolpidem (Ambien)..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Medication for Chronic Pain Page(s): 60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Zolpidem.

**Decision rationale:** The patient does have persistent pain complaints and disturbances in sleep patterns related to the patient's chronic pain. The Official Disability Guidelines recommend this medication for short courses of treatment for insomnia related to chronic pain. However, The California MTUS guidelines state that medications used in the management of chronic pain must be supported by increased functional benefit and symptoms response. The clinical documentation submitted for review does provide evidence that the patient has had a longstanding history of sleep disturbances secondary to their pain and has taken this patient intermittently. However, the documentation does not provide evidence that this patient has any functional benefit or symptom resolution as a result of the medication usage. As such, the prospective request for 1 prescription of Ambien controlled release (CR) 12.5 mg #30 between 08/30/2013 and 11/03/2013 is not medically necessary or appropriate.

**Prevacid 30mg, #60 with 2 refills:** 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), Section Prevacid.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

**Decision rationale:** The clinical documentation submitted for review does provide evidence that the patient has chronic pain complaints with a diagnosis of gastrointestinal upset related to medications. However, the California MTUS guidelines recommend a gastrointestinal protectant when the patient is at risk for developing gastrointestinal events. The clinical documentation submitted for review does not provide any evidence that the patient is at risk for developing gastrointestinal issues as a result of the medication usage. Although it is stated that the patient has gastroc upset, there are no objective clinical findings to support this statement. Therefore, the efficacy of this medication cannot be established. As such, the prospective request for 1 prescription of Prevacid 30 mg #60 with 2 refills between 08/30/2013 and 12/03/2013 is not medically necessary or appropriate.