

<b>Case Number:</b>	CM13-0056144		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	11/21/2012
<b>Decision Date:</b>	04/14/2014	<b>UR Denial Date:</b>	11/07/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/21/2013

### 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 and Rehabilitation and Pain Management, 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 25 year old male with date of injury 11/21/12. The treating physician report dated 9/18/13 indicates that the patient has pain affecting the lumbar spine traveling into the legs posteriorly to the knees. The current diagnoses are: 1.Displacement of lumbar intervertebral disc without myelopathy. 2.Lower back pain with bilateral lower extremity radiculopathy 3.Lumbar facet joint syndrome 4.Myalgia 5.Insomnia The utilization review report dated 11/7/13 denied the request for Fioricet and Ambien and modified the request for Ultracet based on the rationale that the requested medications are not supported by the MTUS guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultracet 37.5-325mg (#60 with 2 refills) QTY: 180.00:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74.

**Decision rationale:** The patient presents with chronic lumbar pain and posterior leg pain bilaterally to the knees. MRI report dated 5/16/13 shows L4/5 2.5mm posterior disc protrusion.

In reviewing the 848 pages contained in this review, the treating physician does not actually prescribe Ultracet, Fioricet or Ambien. There are statements in his reports that state the patient is taking the medications. There is no indication as to what benefit the patient has with these medications. The MTUS guidelines state in reference to medication usage, "Medication to be used as directed to cure or for relief of injury or condition related to the industrial injury. Use of medication, especially oral medications will be monitored closely for effectiveness and possible dependency." There are no before and after pain assessments provided in the reviewed reports, nor are there any functional gains documented. MTUS requires a pain assessment and evaluation of function for use of Opioid medications over a period of time. Specifically, MTUS requires functioning documentation using a numeric scale or a validated instrument once every 6-months. Under outcome measures, MTUS also requires current level of pain; average pain; least pain; pain reduction with medication; duration of relief, etc., which should be documented for continued use of opiates for chronic pain. The treating physician does not provide any of these required measurements for continued use. Recommendation is for denial.

**Fioricet (#60 with 2 refills) QTY: 180.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**Decision rationale:** The patient presents with chronic lumbar pain and posterior leg pain bilaterally to the knees. The request is for Fioricet which contains acetaminophen, butalbital (barbiturates) and caffeine. The MTUS guidelines state that barbiturate containing analgesic agents (BCAs) are not recommended for chronic pain. The treating physician has not documented any rationale for the usage of this medication. Recommendation is for denial.

**Ambien 10mg (#30 with 2 refills) QTY: 90.00: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The patient presents with chronic lumbar pain and posterior leg pain bilaterally to the knees. This request is for Ambien. Ambien (zolpidem) is not addressed in the MTUS guidelines. The ODG guidelines state that zolpidem is approved for the short-term (usually 2 to 6 weeks) for treatment of insomnia. The 8/23/13 treating physician report indicates that the patient is prescribed Ambien 10mg (#30 w/2 refills). The patient has been taking zolpidem for longer than six weeks and MTUS is specific that this medication is for short term usage only. Recommendation is for denial.