

<b>Case Number:</b>	CM13-0059877		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	10/16/2001
<b>Decision Date:</b>	05/15/2014	<b>UR Denial Date:</b>	11/05/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/02/2013

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 injured worker is a 47-year-old male who reported an injury on 10/16/2001 after dislodging a cord that was stuck, which reportedly caused injury to his low back. Treatment history has included physical therapy, functional restoration program, multiple medications, a TENS unit, and a home exercise program. The injured worker was monitored for aberrant behavior with urine drug screens. The injured worker was evaluated on 08/01/2013. It was documented that the injured worker had 7/10 to 8/10 pain without medications, and reduced to a 3/10 to 4/10 with medications. Physical findings included reduced range of motion of the lumbar spine with positive tenderness and spasming to palpation and a positive left-sided straight leg raising test, and decreased sensation in the L5 dermatomal distribution. The injured worker's diagnoses included lumbar degenerative disc disease, facet arthropathy of the L4-5 and L5-S1 with radiculopathy, avascular necrosis of the bilateral hips, depression, and chronic pain. The injured worker's treatment recommendations included continuation of medications for 3 months.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ONE (1) PRESCRIPTION OF NORCO 10/325MG, #90, WITH THREE (3) REFILLS:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On Going Management Page(s): 78.

**Decision rationale:** The requested Norco 10/325mg, #90, with three (3) refills is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends ongoing assessments of pain relief, functional benefit, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does not clearly identify any functional benefit related to this medication. Although the injured worker does have adequate pain relief and is monitored for aberrant behavior with urine drug screens, continued use would not be supported. Additionally, the request is for 3 refills. In consideration of the injured worker's history of aberrant behavior, this would not allow for timely re-assessment and re-evaluation of the injured worker's response to this medication and evaluation for aberrant behavior. Additionally, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Norco 10/325mg, #90, with three (3) refills is not medically necessary or appropriate.

**ONE (1) PRESCRIPTION OF AMBIEN 10MG, #25, WITH THREE (3) 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), Pain (Chronic), Zolpidem (Ambien)

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

**Decision rationale:** The requested Ambien 10mg, #25, with three (3) refills is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this medication. Official Disability Guidelines do not recommend long term use of this medication. The clinical documentation submitted for review does indicate that the injured worker has been on this medication for an extended duration. Also, the most recent clinical evaluation does not provide an adequate assessment of the injured worker's sleep hygiene to support the efficacy of this medication, therefore justifying continued use. Also, the request as it is submitted does not provide an appropriate length of time to re-assess and re-evaluate the injured worker's response to this medication as the request is for 3 refills. Also, the request as it is submitted does not indicate a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Ambien 10mg, #25, with three (3) refills is not medically necessary or appropriate.