

<b>Case Number:</b>	CM13-0060788		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	07/18/2011
<b>Decision Date:</b>	05/22/2014	<b>UR Denial Date:</b>	11/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/04/2013

### 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 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 injured worker is a 44-year-old male who reported an injury on 07/18/2011. The mechanism of injury was not provided for review. The injured worker's treatment history included physical therapy, medications, and chiropractic treatment. The injured worker was evaluated on 11/05/2013. It was documented that he had continued pain complaints of the lumbosacral spine, with tenderness and spasming, reduced range of motion. The injured worker's diagnoses included lumbosacral discopathy and stress. A prescription was written on 11/11/2013 for Ambien, Soma, Prilosec, and Norco. Clinical documentation indicated that the injured worker had been prescribed these medications since at least 10/2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**HYDROCODONE (NORCO) 10/325MG #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids. Page(s): 76.

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

**Decision rationale:** The requested Hydrocodone (Norco) 10/325 mg #90 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the

ongoing use of opioids in the management of chronic pain be supported by documentation of functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the injured worker has a history of consistent urine drug screens. However, the most recent clinical evaluation fails to provide any evidence of functional benefit or significant pain relief resulting from medication usage. Therefore, ongoing usage would not be supported. Also, the request as it is submitted does not provide a frequency of treatment. The appropriateness of the request cannot be determined without this information. As such, the requested Hydrocodone (Norco) 10/325 mg #90 is not medically necessary or appropriate.

**OMEPRAZOLE DR (PRILOSEC) 20MG #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Nsaids, GI Symptoms & Cardiovascular Risk, Page(s): 68.

**Decision rationale:** The requested Omeprazole (Prilosec) 20 mg #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends ongoing use of gastrointestinal protectants be supported by an evaluation to determine the injured worker's ongoing risk factors for developing gastrointestinal events related to medication usage. The clinical documentation submitted for review did not provide an adequate assessment of the injured worker's gastrointestinal system to support that they are at continued risk for developing disturbances related to medication usage. Therefore, ongoing use of this medication would not be supported. Additionally, the request does not include a frequency of treatment. The appropriateness of the request cannot be determined without this information. As such, the requested Omeprazole (Prilosec) 20 mg #60 is not medically necessary or appropriate.

**CARISOPRODOL (SOMA) 350MG #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Page(s): 29, 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Page(s): 63.

**Decision rationale:** The requested Carisoprodol (Soma) 350 mg #90 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not support the use of muscle relaxants in the management of chronic pain. It is documented within the guidelines that treatment should Final Determination Letter for IMR Case Number CM13-0060788 4 be limited to 2 to 3 weeks for acute exacerbations of chronic pain. The clinical documentation does not indicate that this is an acute exacerbation that would benefit from the short-term use of a muscle relaxant. Additionally, the request is for a quantity of 90 pills. This exceeds the duration of treatment recommended by California Medical Treatment Utilization Schedule. 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 Carisoprodol (Soma) 350 mg #90 is not medically necessary or appropriate.

**ZOLPIDEM TARTRATE (AMBIEN) 10MG #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, Pain Chapter, Online Version: 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 Zolpidem Tartrate (Ambien) 10 mg #30 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this medication. Official Disability Guidelines recommend the short-term use of this medication to assist with stabilizing an injured worker's sleep patterns that are disrupted by chronic pain. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's sleep hygiene to support the need for pharmacological intervention. Additionally, the most recent clinical documentation does not provide any evidence that the injured worker has failed to respond to non-pharmacological interventions. Therefore, continued use of this medication would not be supported. Additionally, the request as it is submitted does not provide a frequency of treatment. The appropriateness of the request cannot be determined without this information. As such, the requested Zolpidem Tartrate (Ambien) 10 mg #30 is not medically necessary or appropriate.