

<b>Case Number:</b>	CM13-0066876		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	10/16/2006
<b>Decision Date:</b>	05/22/2014	<b>UR Denial Date:</b>	12/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/17/2013

### 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 Family Practice and is licensed to practice in 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 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 38-year-old male who reported an injury on 10/16/2006. The injury reportedly occurred in the course of his usual work duties. The injured worker's diagnoses included lumbar post-laminectomy syndrome, lumbar radiculopathy, lumbar spine fusion, myositis/myalgia, depression, vitamin D deficiency, and chronic pain. On 02/11/2014, he complained of neck pain that radiated bilaterally down the upper extremities and low back pain radiating down the lower extremities, along with ongoing headaches. He rated his pain as 9/10 with medications and 10/10 without medications and the pain has been unchanged since the last office visit. Medications were noted to include Tramadol, Pantoprazole, Zolpidem, and Glucosamine-Chondroitin. The Insomnia Severity Index test was administered on 02/11/2014 and the total score was 27. Based on this score, it was determined the injured worker had severe clinical insomnia. The treatment plan included a urine drug screen and to follow-up in 1 month. There was no date or rationale noted for the request of Tramadol, Pantoprazole, Zolpidem, and Glucosamine-Chondroitin

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TRAMADOL ER 150MG #60:** Upheld

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

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

**Decision rationale:** The request for Tramadol ER 150 mg #60 is not medically necessary. The injured worker has complained of neck and lower back pain, which radiates down the extremities. The severity of the pain has continued to be 9/10 with medications and 10/10 without medications. The documentation provided failed to provide evidence of significant pain relief, increased functionality or increased activities of daily living as a result of the medications. According to California MTUS Guidelines, the ongoing management of opioids should include detailed documentation of pain relief, functional status, and the "4 As" for ongoing monitoring which include analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The frequency of the medication was not provided in the request as submitted to determine necessity. In summary, the documentation provided for review fails to show functional improvements in pain relief proving the effectiveness of the medication. Further, the documentation did not indicate whether the injured worker complained of adverse effects. Moreover, the injured worker did submit to a random urine drug test to show medication compliance; however, the results of this screen were not provided. The request as submitted did not include the frequency in which the patient was to take the medication. In the absence of the detailed documentation required by guidelines for ongoing use of opioid medications, the request is not supported. Therefore, the request for Tramadol ER 150 mg #60 is not medically necessary and appropriate.

**PANTOPRAZOLE 20MG #30:** Upheld

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

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

**Decision rationale:** The request for Pantoprazole 20 mg #30 is not medically necessary. The injured worker has complained of neck and back pain both which radiate bilaterally to the extremities. The severity of the pain was 9/10 with medication and 10/10 without medication. On 02/11/2014, the injured worker had no gastrointestinal complaints. CA MTUS supports the on-going use of gastrointestinal protectants for injured workers who are at risk for developing gastrointestinal disturbances related to medication usage. The clinical documentation submitted for review does not provide a recent assessment of the injured worker's gastrointestinal system to support that they have an on-going risk for developing symptoms that would require a gastrointestinal protectant. Therefore, continued use of this medication is not supported. The frequency of the medication was not provided in the request as submitted to determine necessity. In summary, the documentation provided for review fails to show signs or symptoms of gastrointestinal problems and the request as submitted fails to provide the frequency of the requested medication. Therefore, the request for Pantoprazole 20 mg #30 is not medically necessary and appropriate.

**ZOLPIDEM 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 (ODG), Zolpidem.

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

**Decision rationale:** The request for Zolpidem 10 mg #30 is not medically necessary. On 02/11/2014, the injured worker had Insomnia Severity Index screening completed and the injured worker had a score of 27. Based on the score, it was determined the injured worker has severe clinical insomnia. According to Official Disability Guidelines, Zolpidem is a non-benzodiazepine sedative hypnotic and is a first-line medication for insomnia. Zolpidem is indicated for short-term treatment of insomnia; studies have shown that it is to be effective for up to 24 weeks in adults. The documentation submitted for review fails to include duration that the injured worker has been utilizing Zolpidem. In addition, the Insomnia Severity Index that was taken shows the injured worker is still in the severe insomnia level with use of the Zolpidem which reveals the ineffectiveness of the Zolpidem. The frequency of the medication was not provided in the request as submitted to determine the necessity. Therefore, the request for Zolpidem 10 mg #30 is not medically necessary and appropriate.

**GLUCOSAMINE-CHONDROITIN DS 500/400 #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine Chondroitin Sulfate Page(s): 50.

**Decision rationale:** The request for Glucosamine-Chondroitin DS 500/400 #60 is not medically. The injured worker complained of neck and lower back pain, both radiating down the upper extremities and lower extremities bilaterally; the severity of the pain has continued to be 9/10 with medication and 10/10 without medications. According to California MTUS Guidelines, Glucosamine is recommended as an option given its low risk in patients with moderate arthritis pain, especially for knee arthritis. The documentation provided for review fails to show the injured worker had arthritic pain or any type of arthritic diagnosis. The frequency of the medication was not provided in the request as submitted to determine necessity and there was a lack of information regarding the efficacy of the medication to support continuation. Therefore, the request for Glucosamine-Chondroitin DS 500/400 #60 is not medically necessary and appropriate.