

<b>Case Number:</b>	CM14-0126361		
<b>Date Assigned:</b>	08/13/2014	<b>Date of Injury:</b>	07/20/1994
<b>Decision Date:</b>	09/18/2014	<b>UR Denial Date:</b>	07/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/08/2014

### 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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 61-year-old female who reported an injury on 07/20/1994. The mechanism of injury involved a fall. The current diagnoses include myofascial pain/myositis, carpal tunnel syndrome, sciatica, lumbosacral neuritis or radiculitis, ulnar neuropathy, and cervical radiculopathy. The injured worker was evaluated on 07/16/2014 with complaints of neck pain, back pain, and left knee pain. It is noted that the injured worker has been previously treated with physical therapy, acupuncture, epidural steroid injections, and bracing. The current medication regimen includes Colace, promethazine, Norco 10/325 mg, Biofreeze, gabapentin 800 mg, omeprazole, and quazepam. Physical examination on that date revealed no apparent distress. Treatment recommendations at that time included prescriptions for Ambien CR 6.25 mg, morphine sulfate ER 10 mg, Norco 5/325 mg, and Biofreeze 4%. A Request for Authorization form was not submitted on the requesting date. A previous Request for Authorization form was submitted on 04/21/2014 for Norco, Ambien, Xanax, and Gabapentin.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Gabapentin 800 mg # 90 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-19.

**Decision rationale:** The California MTUS Guidelines state Gabapentin is recommended for neuropathic pain. The injured worker has continuously utilized this medication since 04/2014 without any evidence of objective functional improvement. There was also no frequency listed in the request. As such, the request is not medically necessary.

**Norco 10/325 mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has continuously utilized this medication since 04/2014 without any evidence of objective functional improvement. There is also no frequency listed in the request. As such, the request is not medically necessary.

**Ambien 12.5 mg #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, Treatment in Worker's Compensation, Pain Procedure Summary, (last updated 05/15/2014), Zolpidem.

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

**Decision rationale:** The Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. The injured worker has continuously utilized this medication since 04/2014 without any evidence of objective functional improvement. There was no documentation of a failure to respond to nonpharmacologic treatment. There was also no frequency listed in the request. As such, the request is not medically necessary.