

<b>Case Number:</b>	CM14-0159708		
<b>Date Assigned:</b>	10/03/2014	<b>Date of Injury:</b>	02/23/2000
<b>Decision Date:</b>	10/31/2014	<b>UR Denial Date:</b>	09/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2014

### 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 Occupational Medicine and is licensed to practice in Colorado. 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 57 year old male with a date of injury on 2/23/2000. The injury resulted in neck, back and left shoulder pain. He is status post L4-S1 fusion with instrumentation on 3/12/2012 and status post cervical surgery C4-C7 on 3/20/13. He has treated with prior therapy, acupuncture and injections and remains off work. The most current medical notes state that there was still some neck, shoulder and low back pain. There were findings of spinal spasm, limited neck motion, reduced range of motion, tenderness cervical and lumbar spine, and neuro loss numbness. Plan is for home exercise program, Norco, Ambien, and physical therapy (PT). A magnetic resonance imaging (MRI) of left shoulder on 2/28/14 notes tendinosis supraspinatus, no tears, osteophyte spurring humeral head.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2 x 4 to low back:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

**Decision rationale:** Based on a review of the documents provided, the requested Physical Therapy 2x4 to the low back is not medically necessary. The requested treatment/service is not medically necessary because the request does not meet the criteria of the medical treatment guidelines as there is a lack of documentation to support additional physical therapy 14 years after his initial injury. The medical guidelines note that supportive documentation should be provided indicating the injured worker's functional improvement regarding prior therapy and documentation of clinical findings to support ongoing treatment. After the acute to subacute phase of injury an independent exercise program is recommended by the guidelines for maintenance care. This injured worker is 14 years post injury and lumbar fusion with ongoing symptoms and no findings of any significant change in his condition. There is no documentation as to any previous functional improvement following the previous physical therapy that was rendered. Thus, the request does not meet the criteria of the guidelines and an independent exercise maintenance regimen is recommended by the medical treatment guidelines to maintain function and control pain. The request is not medically necessary.

**Norco 10/325mg x 60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76.

**Decision rationale:** The requested Norco 10/325mg x 60 is not medically necessary. The requested treatment/service is not medically necessary as there is a lack of documentation as to efficacy of pain relief, functional improvement or status, adverse medication side effects, consideration of alternative non-opioid medications, or aberrant behaviors. The medical treatment guidelines note that ongoing prescribing of opioid medications, Norco, should be supported by documentation of pain relief, functional improvement with the use of the medication, documentation of adverse effects or aberrant behaviors. Also, the guidelines recommend that alternative medication use should be considered. In light of the lack of appropriate documentation as to the efficacy of the use of this medication, the request does not meet criteria of the guidelines. The request is not medically necessary.

**Ambien 10mg X 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), Pain Chapter

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

**Decision rationale:** The requested Ambien 10mg x 30 is not medically necessary. The requested treatment/service is not medically necessary because this medication is not being prescribed as

recommended by the medical treatment guidelines. The medical records reflect chronic use and prescribing of this medication. The medical treatment guidelines note that this medication should be used for short term use only for periods of 3 weeks. Per the authorization letter dated 09/05/14, Ambien was approved for weaning; therefore ongoing treatment would not be medically necessary. Thus, the request does not meet criteria of the guidelines and is not medically necessary.