

<b>Case Number:</b>	CM14-0164596		
<b>Date Assigned:</b>	10/16/2014	<b>Date of Injury:</b>	03/10/2008
<b>Decision Date:</b>	11/18/2014	<b>UR Denial Date:</b>	09/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/07/2014

### 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 Interventional Spine Pain Management 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 patient is a 43-year-old male with a date of injury of 03/10/2008. The listed diagnoses per [REDACTED] are: 1. Chronic low back pain. 2. Chronic right L5 radiculopathy with left-sided radicular symptoms. 3. History of left-sided upper extremity dysesthesia. 4. Insomnia secondary to pain. 5. Constipation secondary to narcotics medication. 6. Depression. 7. Sexual dysfunction. According to progress report, 08/18/2014, the patient presents with low back pain and pain radiating into both legs. He also complains of pain in his shoulders. Examination revealed decreased range of motion in the low back and bilaterally shoulders. There is rotator cuff tenderness noted. Provider reports paraspinal tenderness from L2 to L5, L5 to S1 with spasms. Right sacroiliac tenderness without left sacroiliac tenderness is noted. The provider is requesting a refill of Norco 10/325 mg for pain and Ambien 10 mg for sleep disturbance. Utilization review denied the request on 09/23/2014. Treatment reports from 02/24/2014 through 08/18/2014 were reviewed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg 1 po q 4-6 hours prn #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
CRITERIA FOR USE OF OPIOIDS Page(s): 88-89, 78.

**Decision rationale:** This patient presents with chronic low back and bilateral shoulder pain. The provider is requesting a refill of Norco 10/325 mg #90. The MTUS Guidelines pages 88 and 89 state, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4 A's (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work, and duration of pain relief. The patient has been prescribed Norco since 2/24/14. Review of the medical file does not provide pain assessment or outcome measures as required by MTUS. There is no pain scales to denote decrease in pain, discussion of functional improvement, or changes in ADLs with taking Norco. Furthermore, the provider does not provide random urine drug screens to monitor for drug compliance. Aberrant behaviors are also not discussed. Given the lack of sufficient documentation for opiate management, recommendation for further use cannot be made. Therefore, this request is not medically necessary.

**Ambien 10mg 1 po q hs #30 with 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); regarding Ambien

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

**Decision rationale:** This patient presents with chronic low back and bilateral shoulder pain. The provider is requesting Ambien 10 mg #30 with 3 refills as the patient continues with sleep disturbances. The MTUS and ACOEM Guidelines do not address Ambien. However, ODG Guidelines under its pain section states that Zolpidem (Ambien) is indicated for short-term treatment of insomnia with difficulty of sleep onset 7 to 10 days. The medical file indicates that the patient has been taking Lunesta 2 mg with continued insomnia. The provider recommended Ambien 10 mg. In this case, the provider has prescribed Ambien for long-term use; therefore, this request is not medically necessary.