

<b>Case Number:</b>	CM14-0170331		
<b>Date Assigned:</b>	10/20/2014	<b>Date of Injury:</b>	05/03/2002
<b>Decision Date:</b>	11/20/2014	<b>UR Denial Date:</b>	09/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2014

### 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 and Rehabilitation, has a subspecialty in Interventional Spine 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 61-year-old female with a date of injury of 05/03/2002. The listed diagnoses per [REDACTED] are: 1. Chronic pain, other. 2. Lumbar facet arthropathy. 3. Failed back surgery syndrome, lumbar. 4. Lumbar radiculopathy. 5. Right wrist pain. 6. Insomnia. 7. Medication-related dyspepsia. 8. Status post spinal cord stimulator. According to progress report 09/10/2014, the patient presents with neck and low back pain and complains of insomnia. Pain is rated as 3/10 with medication and 8/10 without medication. The patient reports activities of daily living limitations and self-care hygiene activity, ambulation, hand function, and sleep. The patient reports that current medications are "helpful." Examination of the lumbar spine revealed spasm noted in the bilateral paraspinous musculature and tenderness noted upon palpation in the bilateral paravertebral area of the L4 to S1 levels. Pain was significantly increased with flexion and extension. Straight leg raise in the seated position was positive at 50 degrees bilaterally. The patient's current medication regimen includes Ambien, Flexeril, gabapentin, Lyrica, tramadol ER, and Norco 10/325 mg. The treater is requesting a refill of Norco and Ambien. Utilization review denied the request on 09/16/2014. Treatment reports from 12/05/2013 through 09/10/2014 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, #120:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids Page(s): 88 89 78.

**Decision rationale:** The treater is requesting a refill of Norco 10/325mg, #120. Utilization review modified the certification from the requested #120 to #72 between 08/14/2014 and 11/10/2014. Utilization review indicates that the patient was instructed to wean from this medication on 05/07/2014. 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. Review of the medical file indicates the patient has been taking Norco since at least 12/05/2013. On 01/02/2014, patient reported a decrease in pain from 4/10 to 2/10 with current medications. The patient reports that current medications are "helpful." It was noted the patient is compliant with medications and potential adverse side effects were discussed. On 06/18/2014, the patient noted a decrease of pain from 7/10 to 2/10 with medications and she noted overall 50% to 80% improvement in her pain and functional improvement with medications. Report 09/10/2014 indicates the patient is able to bathe, dress, shop, sit, stand, and walk in the neighborhood with medications. She also noted improved mobility and improved sleep. The patient reports "Her quality of life has improved as a result of the above treatment." In this case, it appears the patient is currently not working but experiencing a decrease in pain and experiencing specific functional improvement with current medication regimen. The patient is counseled on potential side effects of the prescribed medication and the treater notes that the patient is compliant with medications prescribed. The requested Norco is medically necessary and recommendation is for approval.

**Ambien 10mg, #30:** Upheld

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

**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 chapter Zolpidem (Ambien)

**Decision rationale:** The treater is requesting a refill of Ambien 10mg, #30 as needed for insomnia. Review of the medical file indicates the patient has been prescribed Ambien since at least 06/18/2014. 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. Given that Zolpidem has been prescribed for long term use the request is not medically necessary.

