

<b>Case Number:</b>	CM14-0037866		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	01/09/2002
<b>Decision Date:</b>	08/14/2014	<b>UR Denial Date:</b>	03/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/31/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine 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 47 year old male who had a work related injury on 01/09/02. There is no documentation of the mechanism of injury. The injured worker injured his back and his neck. He had surgery on 03/28/06 which was an L4-5 and L5-S1 posterior lumbar interbody fusion. Then he had hardware removal on 06/06/09. The injured worker has undergone physical therapy, pain management. The injured worker continued to complain of significant amount of leg pain with constant numbness and tingling and a burning sensation to the bilateral feet. He also complains of neck and bilateral upper extremity pain which he describes as a burning, stabbing, and aching with numbness and pins and needles sensation. He indicates his pain level is a 5-6 on a scale of 0-10. Physical examination on 04/29/14 the injured worker has a normal gait. Lumbar spine examination, no kyphosis deformity. There is slight flattening of the lumbar lordosis. Well-healed surgical scar in the posterior lumbar spine region. There is tenderness in the paraspinal musculature of the lumbar region. Midline tenderness is noted in the lumbar region. No muscle spasm in the lumbar region. Flexion to 20 degrees. Extension to 15 degrees. Rotation to the right is 15 degrees. Rotation to the left is 10 degrees. Right lateral bending is 15 degrees and left lateral bending is 15 degrees. Slightly abnormal pinwheel testing. Motor examination is essentially normal. Reflexes are 2+ in the lower extremities. Negative clonus. Diagnosis is cervical spine sprain/strain. The C4-5 and C5-6 right sided neuroforaminal stenosis. Status post L4-5 and L5-S1 posterior lumbar interbody fusion. Status post L4-5 and L5-S1 hardware removal. The injured worker also had 1 urinary drug screen which was consistent with the pain medications that he was taking. There is no documentation of significant functional improvement on medication. Pain scale maintained at 5-6/10. Prior utilization review dated 03/13/14 non-certified for the Ambien, and modified certification for the Tramadol. Current request is for Zolpidem 10mg refilled x 3. Tramadol 50mg #90 refilled x 3.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Zolpidem 10mg refill 3:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Chapter-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 chapter, Zolpidem (Ambien®).

**Decision rationale:** The request for Zolpidem 10mg refilled x 3 is not medically necessary. the clinical documentation submitted for review as well as current evidence based guidelines do not support the request. The Zolpidem is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Therefore medical necessity has not been established.

### **Tramadol 50mg #90 refill 3:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80.

**Decision rationale:** The request for Tramadol 50 mg #90 refillx 3 is not medically necessary. The clinical documentation submitted for review does not support the request for Tramadol. No documentation of functional improvement, and no significant decrease in pain. Prior utilization review modified the request for weaning. As such, medical necessity has not been established.