

<b>Case Number:</b>	CM15-0180882		
<b>Date Assigned:</b>	09/22/2015	<b>Date of Injury:</b>	01/25/1997
<b>Decision Date:</b>	10/28/2015	<b>UR Denial Date:</b>	08/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/14/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Pennsylvania

Certification(s)/Specialty: Family Practice

### 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 59 year old male, who sustained an industrial injury on 1-25-1997. He reported injuries to the head, neck, back, right shoulder, wrist and right knee when he was hit by an automotive vehicle. Diagnoses include bilateral rotator cuff syndrome, lumbar stenosis and radiculopathy, status post multiple shoulder surgeries. Treatments to date include activity modification, medication therapy, physical therapy, and epidural steroid injections. Currently, he complained of ongoing pain in the neck, upper back, mid back, bilateral shoulder and wrists with radiation to bilateral arms, and pain in the lower back, left hip, bilateral knees with radiation to both legs associated with numbness. Pain was rated on average 8-9 out of 10 VAS and at worst rated 10 out of 10 VAS. Current medications included Fioricet, Ambien CR and Hydrocodone. On 7-30-15, the physical examination documented tenderness in cervical and bilateral shoulder muscles with decreased range of motion. There was decreased shoulder strength noted. The appeal requested authorization for Fioricet (unknown strength-quantity), Ambien (unknown strength-quantity), and an electric scooter. The Utilization Review dated 8-24-15, denied the requests indicating the available medical records do not support that the Official Disability Guidelines and California MTUS Chronic Pain Medical Treatment Guidelines were met.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Electric scooter qty 1.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee and Leg.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain/Power Mobility Devices.

**Decision rationale:** The ODG states: "Not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care." According to the record this worker is walking without any assistive device and can walk 2 blocks before stopping due to pain. Therefore this request is not medically necessary.

**Fioricet (unknown strength/quantity) qty 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Barbiturate-containing analgesic agents.

**Decision rationale:** According to the MTUS, "Not recommended for chronic pain. The potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents." The record indicates that this worker is being treated for chronic pain. If the Fioricet is being used to treat any other condition, it is not indicated in the medical record. Therefore this request is not medically necessary.

**Ambien (unknown strength/quantity) qty 1.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Zolpidem (Ambien).

**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.

**Decision rationale:** According to the ODG, Ambien (zolpidem) "is a prescription short-acting non-benzodiazepine hypnotic, which is recommended for short-term (7-10 days) treatment of insomnia." The medical record available for review did not indicate this worker has insomnia. Even if so, no rationale has been provided for Ambien beyond the recommended 7-10 days of treatment. The record does indicate this worker has already been on Ambien for a period of time. Continued use would not be appropriate. Furthermore, this request does not include a quantity or duration upon which a determination could be made even if it could be determined to be appropriate for a limited duration. Therefore this request is not medically necessary.