

<b>Case Number:</b>	CM15-0031665		
<b>Date Assigned:</b>	02/25/2015	<b>Date of Injury:</b>	09/30/2003
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/19/2015

### 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: California, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 56-year-old female who reported an injury on 09/30/2003 due to an unspecified mechanism of injury. On 02/12/2015, she presented for a follow-up evaluation regarding her work related injury. She reported low back pain rated at a 10/10 without medications and a 7/10 with medications. The pain was associated with numbness and tingling. She also reported neck pain that radiated into the left upper extremity with associated tingling and pain in the left shoulder associated with weakness. Her medications included fentanyl 25 mcg per hour 1 patch every 72 hours, gabapentin 300 mg 3 times a day, hydroxyzine HCL 25 mg 1 tablet 3 times a day, insulin, meclizine 25 mg, oxycodone 30 mg 1 tablet every 3 hours, trazodone 100 mg 1 tablet every day, Ventolin, and zolpidem 1 tablet at bedtime as needed. A physical examination of the cervical spine showed tenderness of the trapezius and rhomboids on the left and right and range of motion was associated with pain. There was decreased sensation and diminished reflexes also noted on examination. She had an antalgic gait and was noted to be ambulating with a walker and there was also tenderness of the sacrum, paraspinal region at the L5, and the gluteus maximus. Range of motion was noted to be decreased and motor strength was noted to be decreased in the left ankle dorsiflexion tibialis anterior and great toe extension extensor hallucis longus as well as in the plantar flexion gastrocnemius. She was diagnosed with degeneration of the cervical intervertebral disc, chronic pain syndrome, knee pain, lumbosacral radiculitis and lumbar postlaminectomy syndrome. The treatment plan was for hydrazine HCL 25 mg #90 with 5 refills and zolpidem 10 mg #30 with 3 refills. The rationale for treatment was not stated.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydroxyzine HCL 25mg # 90 with 5 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18-19.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 78.

**Decision rationale:** The California MTUS Guidelines that an ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects be performed during opioid therapy. While it was noted that the injured worker was having a quantitative decrease in pain with the use of this medication, there was a lack of objective findings indicating that she has had any significant functional improvement to support the request. Also, the frequency of the medication was not supplied within the request. Furthermore, 5 refills of this medication would not be supported without a re-evaluation. Therefore, the request is not supported. As such, the request is not medically necessary.

**Zolpidem10mg #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.

**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:** The Official Disability Guidelines recommend zolpidem for the treatment of insomnia. It is also stated that treatment should not exceed 7 to 10 days. The documentation provided does not show that the injured worker has had a significant improvement in her sleep with the use of this medication to support its continuation. Also, it is unclear how long she has been using zolpidem and without this information, continuing would not be supported as it is only recommended for 7 to 10 days. Furthermore, 3 refills of the medication would not be supported without a re-evaluation and the frequency of the medication was not stated within the request. Therefore, the request is not supported. As such, the request is not medically necessary.