

<b>Case Number:</b>	CM15-0055326		
<b>Date Assigned:</b>	03/30/2015	<b>Date of Injury:</b>	09/19/2011
<b>Decision Date:</b>	08/04/2015	<b>UR Denial Date:</b>	02/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/23/2015

### 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, North Carolina  
 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 57 year old male, who sustained an industrial injury on 09/19/2011. He has reported injury to the low back. The diagnoses have included lumbago; lumbar degenerative disc disease; lumbosacral radiculopathy; and insomnia. Treatment to date has included medications, diagnostics, massage, TENS (transcutaneous electrical nerve stimulation) unit trial, physical therapy, and home exercise program. Medications have included Dilaudid, Meloxicam, Ambien, and Restoril. A progress report from the treating physician, dated 11/05/2014, documented a follow-up visit with the injured worker. The injured worker reported that he has noted some improvement with the start of massage therapy; he has undergone 2 treatments of 12 and has noticed significant improvement in his pain; he is awaiting his TENS unit, which was also of big benefit to him in the TENS unit trial; he is suffering from low back pain on a regular basis with occasional bilateral posterior knee pain; he continues to use Dilaudid and Temazepam on a regular basis for pain; and he has been able to perform his daily routine activities without significant side effects or difficulties. Objective findings included tenderness to palpation of the lumbosacral junction; range of motion is limited in regards to flexion and extension secondary to pain; and sensory, motor, and reflex exams are intact to the bilateral lower extremities. The treatment plan has included the request for Ambien CR 12.5mg #30; and Dilaudid 4mg #90.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien CR 12.5mg # 30:** 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) Integrated Treatment Disability Duration Guidelines, Stress and mental illness chapter.

**Decision rationale:** This claimant has cumulative back trauma with a DOI listed as 9/9/11. He has been prescribed Temazepam, a benzodiazepine, for insomnia, however the medication is no longer effective. The request is now for Ambien 12.5 mg CR. Ambien is a short-acting non-benzodiazepine recommended for short-term (7-10 days) treatment of insomnia. The prescription for #30 Ambien CR exceeds the recommended guideline. Ambien is not indicated for chronic use do to tolerance of hypnotic effects developing rapidly and anxiolytic effects occurring within months. The patient has already failed a previous hypnotic and it is likely that Ambien will have a similar result. Therefore, the request is deemed not medically necessary or appropriate.

**Dilaudid 4mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80.

**Decision rationale:** This claimant has cumulative back trauma with stated DOI of 9/9/11. He is currently prescribed up to three 4 mg tablet/day. The CA MTUS states that opioids are efficacious for acute pain, but should be limited to short-term usage (less than 16 weeks). There is no documentation presented for review that indicates that continued use of Dilaudid is necessary for the 2011 injury. There is also no documentation of increased pain relief or functional improvement allowing the patient to return to work with the chronic use of Dilaudid. Therefore, the request is deemed not medically necessary or appropriate at this time.