

<b>Case Number:</b>	CM14-0130788		
<b>Date Assigned:</b>	08/20/2014	<b>Date of Injury:</b>	11/22/2011
<b>Decision Date:</b>	09/26/2014	<b>UR Denial Date:</b>	07/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/15/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 59-year-old male who reported an injury on 11/22/2011. The mechanism of injury reported was when the injured worker was developing a case of wine. The previous treatments included medication. The diagnoses included lumbar degenerative changes, thoracic or lumbosacral neuritis or radiculitis, pain in joint, and unilateral inguinal hernia. Within the clinical note dated 07/02/2014, it was reported the injured worker complained of low back pain. The diagnostic imaging included a magnetic resonance imaging (MRI) and Electromyogram (EMG) and Nerve Conduction Studies (NCV). On the physical examination, the provider noted the injured worker had pain in his hip and low back with passive range of motion of the right hip. The provider noted the range of motion was greatly reduced in the cervical spine. The injured worker had tenderness to palpation of the upper trapezius area. The provider noted the range of motion of the lumbar spine was 50% of expected. The injured worker had tender trigger points in the lower lumbar area bilaterally. The provider noted tenderness over the lower facet joints. The provider requested Norco and Ambien. However, the rationale was not provided for clinical review. The Request for Authorization was provided and submitted on 07/23/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10-325mg tablet, take one TID #90 (Prescribed 7-2-14): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chapter.

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

**Decision rationale:** The request for Norco 10-325mg tablet, take one TID #90 (Prescribed 7-2-14) is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) Guidelines recommend ongoing and review of documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The provider failed to document an adequate and complete assessment within the documentation. The injured worker's been utilizing the medication since at least 07/2014. Additionally, the use of a urine drug screen was noted provided for clinical review.

**Ambien CR 12.5mg, take one qhs, #30, 3 refills (Prescribed 7-2-14):** Upheld

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

**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 request for Ambien CR 12.5mg, take one qhs, #30, 3 refills (Prescribed 7-2-14) is not medically necessary. The Official Disability Guidelines note Zolpidem is a prescription short acting non benzodiazepine hypnotic, which was approved for short term, usually 2 to 6 weeks, treatment of insomnia. There is lack of documentation indicating the injured worker is treated for and diagnosed with insomnia. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. Therefore, the request is not medically necessary.