

<b>Case Number:</b>	CM14-0136631		
<b>Date Assigned:</b>	09/03/2014	<b>Date of Injury:</b>	04/02/2008
<b>Decision Date:</b>	10/09/2014	<b>UR Denial Date:</b>	08/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/22/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 records presented for review indicate that this 58 year-old female was reportedly injured on April 2, 2008. The mechanism of injury is noted as Cumulative and repetitive stress. The most recent progress note, dated August 26, 2014. Indicates that there are ongoing complaints of bilateral upper extremity pain. The physical examination demonstrated Right shoulder: limited flexion/abduction 90. Positive Hawkins/Neer. Positive speeds. Positive tenderness to palpation in the biceps groove and sub deltoid bursa. Right elbow: positive Tinel's sign, pain with resistant wrist extension. Tinel's sign left elbow, and bilateral wrists. Motor testing is limited by pain. Muscle strength 5/5 upper and lower extremities. Decreased sensation to light touch over thumb, index, middle, ring, small finger and medial hand. Lateral hand on both sides. Reflexes equal bilaterally. No recent diagnostic imaging studies are submitted for review. Previous treatment includes medications. A request had been made for Norco 10/325 mg #60, Duragesic patch #10, Ambien 12.5 mg #30, Intermezzo 1.75 mg #10, Wellbutrin 150 mg #90, and was not certified in the pre-authorization process on August 21, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco (Hydrocodone/APAP) 10/325, sixty count:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78, 88, 91 of 127.

**Decision rationale:** Norco (hydrocodone/acetaminophen ) is a short acting opiate indicated for the management in controlling moderate to severe pain. This medication is often used for intermittent or breakthrough pain. The California MTUS guidelines support short-acting opiates at the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The injured employee has chronic pain; however, there is no objective clinical documentation of improvement in their pain or function with the current regimen. As such, this request for Norco (Hydrocodone/APAP) 10/325, sixty count, is not medically necessary or appropriate.

**Duragesic (Fentanyl) 25mcg/hr, ten count:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44, 93 of 127.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines support long-acting opiates in the management of chronic pain when continuous around-the-clock analgesia is needed for an extended period of time. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. Treatment guidelines specifically state Fentanyl is "not recommended for musculoskeletal pain." Review of the available medical records, fails to document improvement in pain or function with the current treatment regimen. Therefore, the request for Duragesic (Fentanyl) 25 mcg/hr, ten count, is not medically necessary or appropriate.

**Ambien CR (Zolpidem CR) 12.5 mg, thirty count:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - TWC/ODG Integrated Treatment/Disability Duration Guidelines; Pain (Chronic) - Ambien (updated 09/10/14)

**Decision rationale:** MTUS/ACOEM practice guidelines do not address this request; therefore the ODG was used. Zolpidem (Ambien) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. The guidelines specifically do not recommend them for long-term use for chronic pain. As such,

the request for Ambien CR (Zolpidem CR) 12.5 mg, thirty count, is not medically necessary or appropriate.

**Intermezzo (Zolpidem Tartrate Sublingual) 1.75 mg, ten count: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - TWC/ODG Integrated Treatment/Disability Duration Guidelines; Pain (Chronic) - Ambien (updated 09/10/14)

**Decision rationale:** MTUS/ACOEM practice guidelines do not address this request; therefore ODG was used. Zolpidem (Ambien) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. The guidelines specifically do not recommend them for long-term use for chronic pain. As such, the request for Intermezzo (Zolpidem Tartrate Sublingual) 1.75 mg, ten count, is not medically necessary or appropriate.

**Wellbutrin SR (Bupropion SR) 150 mg, ninety count: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Wellbutrin

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16, 27 & 125 of 127.

**Decision rationale:** Bupropion (Wellbutrin) is an atypical antidepressant that acts as a norepinephrine and dopamine reuptake inhibitor. CA MTUS supports its use for the treatment of neuropathic pain; however, there is no evidence of efficiency in patients with non-neuropathic chronic low back pain. As such, the request for Wellbutrin SR (Bupropion SR) 150 mg, ninety count is not medically necessary or appropriate.