

<b>Case Number:</b>	CM14-0161852		
<b>Date Assigned:</b>	10/07/2014	<b>Date of Injury:</b>	04/04/2012
<b>Decision Date:</b>	12/17/2014	<b>UR Denial Date:</b>	09/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/02/2014

### 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 Occupational Medicine and is licensed to practice in California. 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:

Injured worker is a male with date of injury 4/4/2012. Per primary treating physician's progress report dated 9/11/2014, the injured worker complains of persistent aching pain in the low back and bilateral legs. He rates the pain in the low back as 7-8/10 and legs as 5/10. He is taking Ambien, Norco and muscle relaxants. He states the medications are helping. He is not attending therapy. He is not working. On examination the injured worker has difficulty with toe walking on the right. There is tenderness, spasm and guarding of the lumbar and thoracic paraspinal muscles. He can flex to 35 degrees and extend to 10 degrees, tilt to 20 degrees and rotate to 40 degrees bilaterally. There is decreased sensation about the L4, L5, and S1 dermatomes on the left. There is normal sensation on the right. Muscle strength is 5/5 in all major muscle groups of the lower extremities. Deep tendon reflexes are 2+ bilateral and symmetrical. Straight leg raise test is positive on the left and negative on the right. Diagnoses include 1) L5-S1 left sided disc herniation with stenosis, annular tear and left lower extremity radiculopathy 2) insomnia 3) gastrointestinal problems.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien 10mg #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 ODG regarding Ambien for chronic pain

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Insomnia section

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) Guidelines do not address the use of zolpidem. Per the Official Disability Guidelines (ODG), pharmacological agents should only be used for insomnia management after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically whereas secondary insomnia may be treated with pharmacological and/or psychological measures. zolpidem reduces sleep latency and is indicated for the short-term treatment (7-10 days) of insomnia with difficulty of sleep onset and/or sleep maintenance. Adults who use zolpidem have a greater than 3-fold increased risk for early death. Due to adverse effects, FDA now requires lower doses for zolpidem. The requesting physician reports that this prescription is for sleep as needed. The number of tablets and refills indicate that this is expected to be used daily, for four months. The ODG does not recommend chronic use of Ambien. There is no indication that insomnia has been evaluated for psychiatric or medical illness. Medical necessity of this request has not been established within the recommendations of the ODG. The request for Ambien 10mg #30 with 3 refills is determined to not be medically necessary.

**Norco 10/325mg #90 with 3 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Opioids section, Weaning of Medications section

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. The requesting physician reports this prescription is for use as needed for breakthrough pain. The pain assessment does not indicate how frequently the injured worker has breakthrough pain. Functional improvement with the use of Norco is not reported. Pain reduction and improvement in quality of life is not addressed. Aberrant drug behavior is not assessed or addressed. Medical necessity for this request has not been established within the recommendations of the MTUS Guidelines. It is not recommended to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to continue treatment. The request for Norco 10/325mg #90 with 3 refills is determined to not be medically necessary.

