

<b>Case Number:</b>	CM14-0211615		
<b>Date Assigned:</b>	12/24/2014	<b>Date of Injury:</b>	10/20/1999
<b>Decision Date:</b>	02/20/2015	<b>UR Denial Date:</b>	11/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/17/2014

### 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. 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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabn

### 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 61-year-old male who reported an injury on 10/20/1999. His mechanism of injury was not included. His diagnoses included lumbar radiculopathy. His past treatments have included epidural steroid injection, radiofrequency neurotomy, facet steroid injection, and median branch blocks. His diagnostic studies included urine drug screens, MRIs, electromyography. His surgical history included kyphoplasty of compression fractures at T11 and L2, left shoulder arthroscopy, rotator cuff repair, arthroscopic subacromial decompression, extensive debridement of labrum, biceps, and scapula. The progress report dated 01/28/2014 documented the injured had complaints of pain that had begun to radiate down the left leg and bilateral low back pain that he rated at a 7/10. His physical exam findings included lumbar flexion at 120 degrees, lumbar extension was 15 degrees. The neck and cervical exam documented Spurling's test was positive on the right. His medications included gabapentin 600 mg, Flexeril 7.5 mg, Naprosyn 500 mg, Norco 10/325 mg, zolpidem 10 mg, Sentra PM, and Theramine. The treatment plan was recommendation for epidural steroid injection to left L5-S1, diagnostic facet injections bilateral L3-4, L4-5 and L5-S1. If efficacious, proceed with radiofrequency rhizotomy. The rationale for the request is pain management. The Request for Authorization form is signed and dated 02/03/2014 in the medical record.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg QTY: 90.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Ongoing Management Page(s): 78.

**Decision rationale:** The request for Norco 10/325 mg Qty. 90 is not medically necessary. The California MTUS Guidelines state that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be documented. The documentation submitted for review does not include a documented proper pain assessment, improved functional status, CURES report or urine drug screen results, or if any side effects were experienced while taking the medication. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. Therefore, the request for Norco 10/325 mg Qty. 90 is not medically necessary.

**Zolpidem 10mg QTY 30.00:** 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 (Ambien).

**Decision rationale:** The request for Zolpidem 10 mg Qty. 30 is not medically necessary. The Official Disability Guidelines state that Zolpidem is a prescription short acting non-benzodiazepine hypnotic which is recommended for short term, 7 to 10 days, for treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Zolpidem has been prescribed for the injured worker since at least 11/21/2014. As the guidelines recommend short term treatment of insomnia to be 7 to 10 days, the request for Zolpidem 10 mg Qty. 30 is not medically necessary.