

<b>Case Number:</b>	CM14-0095990		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	01/25/2013
<b>Decision Date:</b>	09/24/2015	<b>UR Denial Date:</b>	06/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/24/2014

### 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 48-year-old female who sustained an industrial injury on 1-25-13 when she tripped on a hose causing her to fall back on upper extremity. She was medically evaluated, had x-rays of her back, neck and bilateral upper extremities. Her right hand was casted. She was found to have a left wrist fracture. Per 10-2-13 note the injured worker complains of left hand numbness and tingling. On physical exam of the left hand there was atrophy, decreased sensation to light touch, positive Tinel's, Phalen's and compression test over the carpal tunnel. Diagnoses include left distal radius comminuted intrarticular fracture, status post open reduction internal fixation of left distal radius and comminuted intrarticular fracture (2-5-13); left carpal tunnel syndrome, status post left carpal tunnel release (2-5-13 and 2-20-14). Treatments to date include physical therapy; medications. Diagnostics include electromyography left upper extremity (2-24-13) showing left carpal tunnel syndrome. On 6-10-14 utilization review evaluated requests for Ambien 10mg #30; Fioricet 60 mg #60; Norco 10-325mg #120.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien10mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91. Decision based on Non-MTUS Citation Official Disabilities Guidelines; Pain (Updated 5/15/14) Insomnia Treatment.

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

**Decision rationale:** The current request is for Ambien 10mg #30. The RFA is dated 04/18/14. Treatments to date include CTR 2013 and February 2014, cervical ESI, physical therapy; medications. The patient is TTD. ODG-TWC, Pain (Chronic) Chapter, under Zolpidem (Ambien) states: "Zolpidem is a prescription short-acting non-benzodiazepine hypnotic, which is recommended for short-term (7-10 days) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. (Feinberg, 2008)" Per report 04/03/14, the patient presents with bilateral shoulder/arm and neck pain. On physical exam of the left hand there was atrophy, decreased sensation to light touch, positive Tinel's, Phalen's and compression test over the carpal tunnel. The treater has requested refill of medications. While this patient presents with insomnia, ODG does not support the use of this medication for longer than 7-10 days. Review of the medical file indicates that the patient has been using Ambien since at least 03/15/13. Therefore, the request IS NOT medically necessary.

**Floriset 60mg #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs) Page(s): 22.

**Decision rationale:** The current request is for Fioriset 60mg #60. The RFA is dated 04/18/14. Treatments to date include CTR 2013 and February 2014, cervical ESI, physical therapy; medications. The patient is TTD. MTUS, Barbiturate-containing analgesic agents (BCAs) page 22 states, Not recommended for chronic pain. The potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents. (McLean, 2000) There is a risk of medication overuse as well as rebound headache. (Friedman, 1987) Per report 04/03/14, the patient presents with bilateral shoulder/arm and neck pain. On physical exam of the left hand there was atrophy, decreased sensation to light touch, positive Tinel's, Phalen's and compression test over the carpal tunnel. The treater has requested refill of medications. There is no discussion of this medication. It is unclear if the patient has been utilizing this medication for her chronic pain or if this is a request for continuation. In any case, MTUS does not recommend this medication for chronic pain. This request IS NOT medically necessary.

**Norco 10/325 #120mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain, CRITERIA FOR USE OF OPIOIDS Page(s): 60, 61, 76-78, 88, 89.

**Decision rationale:** The current request is for Norco 10/325 #120mg. The RFA is dated 04/18/14. Treatments to date include CTR 2013 and February 2014, cervical ESI, physical therapy; medications. The patient is TTD. MTUS, CRITERIA FOR USE OF OPIOIDS, pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. MTUS page 77 states, "function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." Per report 04/03/14, the patient presents with bilateral shoulder/arm and neck pain. On physical exam of the left hand there was atrophy, decreased sensation to light touch, positive Tinel's, Phalen's and compression test over the carpal tunnel. The treater has requested refill of medications. The patient has been prescribed Norco since at least 02/01/13. There is no specific discussion regarding medication efficacy. In this case, recommendation for further use cannot be supported as the treating physician has not provided any specific functional improvement, changes in ADLs or change in work status to document significant functional improvement with utilizing long term opiate. There are no before and after pain scales provided to denote a decrease in pain with utilizing long-term opioid. Furthermore, there are no discussions regarding aberrant behaviors or adverse side effects as required by MTUS for opiate management. This request IS NOT medically necessary and recommendation is for slow weaning per MTUS.