

<b>Case Number:</b>	CM15-0126863		
<b>Date Assigned:</b>	07/13/2015	<b>Date of Injury:</b>	02/28/2003
<b>Decision Date:</b>	08/10/2015	<b>UR Denial Date:</b>	06/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2015

### 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: Emergency Medicine

### 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 47-year-old female, who sustained an industrial injury on 2/28/03. The injured worker has complaints of right shoulder pain and right knee pain. The documentation noted that the injured worker has ongoing tenderness throughout the right shoulder with full range of motion in right knee. The diagnoses have included pain in limb. Treatment to date has included norco; voltaren gel; ambien; body massage; status post right shoulder surgery in August 2008; magnetic resonance arthrogram from 8/13/09 showed biceps tendon severe degeneration or tear, no rotator cuff tear; electromyography/nerve conduction study for right upper extremity dated 7/29/10 was normal; arthroscopic surgery with cartilage implant on 7/27/12; magnetic resonance imaging (MRI) of the right shoulder on 3/14/15 showed status post repair of the supraspinatus tendon, there is a background of tendinosis with low-grade partial thickness intrasubstance tear, tendinosis of the infraspinatus tendon with low grade partial thickness articular sided tear and mild reactive bursitis of the subacromial/deltoid bursa and physical therapy. The request was for retrospective norco 10/325mg, #150 dispensed on 05/07/2015 and retrospective ambien 5mg, #30 dispensed on 05/07/2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Norco 10/325mg, #150 dispensed on 05/07/2015: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-79.

**Decision rationale:** Norco is acetaminophen and hydrocodone, an opioid. Patient has chronically been on an opioid pain medication. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. Multiple prior progress notes documented all appropriate sections with appropriate documentation of objective improvement in pain and function as required by MTUS guidelines except for progress note dated 5/7/15. In that note, a brief note stating that there was no change from prior month is not appropriate. However, patient's condition is unchanged and prior documentation supports continued use of opioids. Prior documentation supports last progress notes brief statement that patient is unchanged. Norco is medically necessary.

**Retrospective Ambien 5mg, #30 dispensed on 05/07/2015: 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 - Ambien (zolpidem tartrate); ODG, Pain Chapter - Zolpidem (Ambien).

**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), Insomnia Treatment.

**Decision rationale:** There are no specific sections in the MTUS chronic pain or ACOEM guidelines that relate to this topic. Ambien is a benzodiazepine agonist approved for insomnia. As per ODG guidelines, it recommends treatment of underlying cause of sleep disturbance and recommend short course of treatment. Long-term use may lead to dependency. Patient has been on Ambien chronically. There is no documentation of other conservative attempts at treatment of sleep disturbance or sleep studies. The prescription is excessive and not consistent with short-term use or attempts to wean patient off medication. The chronic use of Ambien is not medically appropriate and is not medically necessary.