

<b>Case Number:</b>	CM13-0029403		
<b>Date Assigned:</b>	11/01/2013	<b>Date of Injury:</b>	04/11/2004
<b>Decision Date:</b>	02/19/2014	<b>UR Denial Date:</b>	09/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/26/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, 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 physician 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 patient is a 41-year-old female who reported an injury on 04/11/2004. The patient is currently diagnosed with history of right shoulder surgery and femoral head replacement, cervical degenerative disc disease, lumbar degenerative disc disease, and significant stress. The patient was recently seen by the provider on 10/09/2013. The patient reported right shoulder and arm pain in addition to low back and posterior neck pain. Physical examination revealed decreased range of motion of the right trapezius and levator scapula, 2 blisters in the right shoulder, 75% lateral and forward flexion, and right hand numbness and tingling in the 2nd, 3rd, and 4th digits. The treatment recommendations included continuation of current medication including ibuprofen, Lidoderm, Ambien, tramadol, Pennsaid, and Phenergan, as well as a request for a cervical epidural injection. &#x2666

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Prospective request for 1 lumbar epidural steroid injection:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

**Decision rationale:** The California MTUS Guidelines state epidural steroid injections are recommended as an option for treatment of radicular pain, with use in conjunction with other rehab efforts. Radiculopathy must be documented by physical examination and corroborated by imaging studies. As per the clinical notes submitted for review, a lumbar epidural steroid injection was requested by the provider on 08/12/2013. It was noted that a repeat injection was indicated following 3 months' improvement from an initial lumbar epidural steroid injection. However, the patient's physical examination on the requesting date of 08/12/2013 revealed only tenderness to palpation of the lumbar spine. The patient demonstrated negative straight leg raising, negative Patrick's testing, and normal motor, sensory, and deep tendon reflexes. There was no documentation of radiculopathy on physical examination. There were also no imaging studies or electrodiagnostic reports submitted for review to corroborate a diagnosis of radiculopathy. Although it is stated that the patient received greater than 50% pain relief following an initial injection, there was no documentation of objective measurable improvement with associated reduction of medication use for 6 to 8 weeks. There was also no evidence of this patient's active participation in a therapeutic exercise program. Based on the clinical information received, the request for 1 lumbar epidural steroid injection is non-certified.

**Prospective request for 1 prescription of Motrin 600mg: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

**Decision rationale:** The California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain. As per the clinical notes submitted for review, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report right upper extremity and low back pain, as well as neck pain. The patient remains on temporary total disability, and there is no evidence of a significant change in the patient's physical examination that would indicate functional improvement. Based on the clinical information received, the request for 1 prescription of Motrin 600mg is non-certified.

**Prospective request for 1 prescription of Zolpidem tartrate 10mg: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter

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

**Decision rationale:** The Official Disability Guidelines (ODG) state insomnia treatment is recommended based on etiology. Zolpidem is indicated for the short-term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. Empirically supported treatment includes stimulus control, progressive muscle relaxation, and paradoxical intention. As per the clinical notes submitted for review, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain with mood and sleep disturbance. Satisfactory response to treatment has not been indicated. As ODG do not recommend chronic use of this medication, the current request cannot be determined as medically appropriate. Therefore, the request for 1 prescription of Zolpidem tartrate 10mg is non-certified.

**Prospective request for 1 prescription of Promethazine 25mg: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Promethazine, Antiemetics.

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

**Decision rationale:** The Official Disability Guidelines (ODG) state promethazine is not recommended for nausea and vomiting secondary to chronic opioid use. Promethazine is recommended as a sedative and anti-emetic in preoperative and postoperative situations. The patient does not currently meet criteria for this medication. Therefore, the request for 1 prescription of Promethazine 25mg is non-certified.

**Prospective request for 1 prescription of Lidoderm 5% patch: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

**Decision rationale:** The California MTUS Guidelines state topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The patient does not demonstrate neuropathic pain upon physical examination. Additionally, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain to the neck, low back, and right upper extremity. There is no evidence of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. Based on the clinical information received, the request for 1 prescription of Lidoderm 5% patch is non-certified.