

<b>Case Number:</b>	CM13-0029557		
<b>Date Assigned:</b>	11/01/2013	<b>Date of Injury:</b>	02/05/2010
<b>Decision Date:</b>	01/28/2014	<b>UR Denial Date:</b>	09/12/2013
<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 and Rehabilitation, and is licensed to practice in Illinois. 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 53-year-old male who reported an injury on 2/5/2010. He is currently diagnosed with rotator cuff tendinitis, sprain and strain of the rotator cuff, spondylosis with myelopathy, degenerative disc disease of the cervical spine, myelopathy, herniated nucleus pulposus of the cervical spine with radiculopathy, osteoarthritis, and pain in a joint. The patient was seen by [REDACTED] on 9/5/13, and reported persistent neck pain. Physical examination revealed lymphadenopathy of the anterior and posterior triangle, decrease range of motion of the cervical spine, decrease abduction of the left arm, radiating pain toward the neck, tenderness of the left biceps tendon, positive impingement sign, positive numbness of the left lower extremity, full range of motion of bilateral hips, knees, and ankles, no edema, and decreased sensation of the left 4th and 5th fingers.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**an adjustable bed [REDACTED]:** 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)

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

**Decision rationale:** The Official Disability Guidelines state that durable medical equipment is recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. It is not recommended to use firmness as a sole criterion for mattress selection. Mattress selection is subjective and depends on personal preference and individual factors. As per the clinical notes submitted, the patient's latest physical examination only revealed diminished range of motion of the cervical spine with positive compression testing. There was no documentation of a significant musculoskeletal deficit. The medical necessity for the requested durable medical equipment has not been established. As such, the request is non-certified.

**Flexeril 10mg, 1 by mouth twice daily, #90 with one refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 65.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

**Decision rationale:** The California MTUS Guidelines state that muscle relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations in patients with chronic low back pain. However, in most lower back pain cases, they show no benefit beyond NSAIDS in pain and overall improvement. Cyclobenzaprine is recommended for a short course of therapy and should not be used for longer than 2-3 weeks. As per the clinical notes submitted, the patient has continuously utilized this medication. Despite the ongoing use, the patient continues to report ongoing neck pain with painful mobility. There has also been no change to the patient's physical examination that would indicate functional improvement. As guidelines do not recommend long-term use of this medication, the current request cannot be determined as medically appropriate. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.

**MRI of the left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state that, for most patients with shoulder problems, special studies are not needed unless a 4-6 week period of conservative care and observation fails to improve symptoms. Primary criteria for ordering imaging studies include the emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, or clarification of the anatomy prior to an invasive procedure. As per the clinical notes submitted, the patient's latest physical examination of the left upper extremity revealed only diminished range of motion with positive impingement sign. There has been no change to the

patient's physical examination findings since 3/21/13. The medical necessity for the requested procedure has not been established. Additionally, failure to respond to recent conservative treatment prior to the request for an imaging study was not provided. Based on the clinical information received, the request is non-certified.

**Norco 10/325mg, 2 by mouth four times a day, #240 with 1 refill: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** The California MTUS Guidelines state that a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Baseline pain and functional assessments should be made, and ongoing reviews of pain relief, functional status, medication use, and side effects should be documented. As per the clinical notes submitted, the patient has continuously utilized this medication since at least 3/21/13. Despite the ongoing use, the patient continues to report persistent neck pain with painful mobility. There are no changes to the patient's physical examination to indicate an improvement. Satisfactory response to treatment has not been indicated by a decrease in the level of pain, increase in the level of function, or overall improved quality of life. Therefore, the ongoing use cannot be determined as medically appropriate. As such, the request is non-certified.

**TENS supplies for the neck and shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

**Decision rationale:** The California MTUS Guidelines state that transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1 month home based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence based functional restoration. There should be documentation of chronic intractable pain at least 3 months in duration, and evidence that other appropriate pain modalities have been tried and have failed. As per the clinical notes submitted, the patient has previously utilized a TENS device. Documentation of significant functional improvement following the use of this treatment modality was not provided. A treatment plan including the specific short and long-term goals of treatment with the unit was also not submitted. Based on the clinical information received, the request is non-certified.

**Zolpidem 10mg, 1 by mouth at bedtime, #30 with one refill: 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)

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

**Decision rationale:** The Official Disability Guidelines state that insomnia treatment is recommended based on etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset for 7-10 days. Empirically supported treatment includes stimulus control, progressive muscle relaxation, and paradoxical intension. As per the clinical notes submitted, there is no indication of a failure to respond to nonpharmacologic treatment prior to the initiation of a prescription medication. The patient has continuously utilized this medication since at least 3/21/13, and it was noted on both 7/24/13 and 9/5/13 that the patient requested Valium to allow him to sleep without difficulty, as opposed to his current regimen of Ambien and Flexeril. Satisfactory response to treatment has not been indicated. As guidelines do not recommend the long-term use of this medication, the current request cannot be determined as medically appropriate. As such, the request is non-certified.