

Case Number:	CM13-0029693		
Date Assigned:	11/01/2013	Date of Injury:	09/20/2004
Decision Date:	01/21/2014	UR Denial Date:	09/07/2013
Priority:	Standard	Application Received:	09/27/2013

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 Internal Medicine, Pulmonary Diseases, 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 43-year-old female who sustained a work related injury on September 20, 2004. The progress report dated September 12, 2013 documented subjective complaints of chronic cervical spine pain, bilateral upper extremity radicular pain, and bilateral hand and wrist pain with paresthasias consistent with carpal tunnel syndrome. The patient reported that the pain was chronic and constant but the medications helped. Physical examination revealed a positive Tinel's, Phalen's, and Durkan's compression test. Cervical spine was positive for spasms, pain, decreased range of motion, and tenderness to palpation. Treatment plan included a referral to an internist, and continuation of the current medication regimen to include Ambien and Norco. The majority of the most recent progress report dated October 29, 2013 is highly illegible. The treatment plan indicated continuation of medication regimen to include Norco, Zanaflex, and Ambien.

IMR ISSUES, DECISIONS AND RATIONALES

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

The prospective request for one (1) prescription of Ambien 10mg, #30 between July 18, 2013 and October 29, 2013: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness and Stress Chapter, Zolpidem.

Decision rationale: While the ODG indicate that non-benzodiazepine sedative hypnotics are considered first line medications for insomnia, zolpidem is only recommended for short-term use, usually 2 to 6 weeks, for the treatment of insomnia. The clinical information suggests that the patient has been utilizing the requested medication since at least April 2013. Given that the documentation submitted for review indicates that the requested medication has been utilized beyond guideline recommendations, the request is not supported. As such, the request for Ambien 10 mg #30 is non-certified.

The prospective request for one (1) prescription of Zanaflex 4mg, #90, between July 18, 2013 and October 29, 2013: 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 Muscle Relaxants Page(s): 63-66.

Decision rationale: The California MTUS Guidelines recommend nonsedating muscle relaxants with caution as a second line option for short-term treatment of acute exacerbations in patients with chronic low back pain; however, in most low back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement, nor are there additional benefit shown in combination with NSAIDs. Additionally, Zanaflex is approved for the management of spasticity and unlabeled use for low back pain. The clinical information submitted for review lacks documentation indicating the patient's past response, duration of use, or any functional improvement and efficacy of the requested medication to support continued use. As such, the request for one (1) prescription of Zanaflex 4 mg #90 between July 18, 2013 and October 29, 2013 is non-certified.

The prospective request for one (1) prescription of Norco 10/325mg, #180, between July 18, 2013 and October 29, 2013: 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 Opioids Page(s): 74-80.

Decision rationale: The California MTUS Guidelines require certain criteria for ongoing monitoring of opioid use. The criteria includes documentation of adverse effects, activities of daily living, aberrant behaviors, and analgesic efficacy. The clinical information submitted for review lacks documentation of the aforementioned criteria. Additionally, the documentation indicates that the patient has been on opioid pain medication on a long-term basis, but there is no

documentation of functional benefit or satisfactory efficacy being obtained though the use of the requested medication. As such, the request for Norco 10/325 mg #180 between July 18, 2013 and October 29, 2013 is non-certified.

one (1) prescription of Biofreeze Gel between July 18, 2013 and October 29, 2013: 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 Topical Analgesics Page(s): 111.

Decision rationale: The California MTUS Guidelines state that topical ointments are largely experimental and have not been shown in properly randomized controlled clinical trials to be effective. Additionally, topical ointments are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The ODG state Biofreeze is not recommended as a stand-alone treatment but recommended as an option in a cognitive behavioral therapy program to facilitate exercise therapy and return to work. There was no clinical information provided for review to indicate the patient's pain was neuropathic in origin, or that lower levels of care had been attempted and failed. The information provided did not indicate the patient was involved in cognitive behavioral therapy. As such, the request for 1 prescription of Biofreeze gel between July 18, 2013 and October 29, 2013 is non-certified.