

Case Number:	CM13-0041461		
Date Assigned:	12/20/2013	Date of Injury:	01/21/2012
Decision Date:	03/05/2014	UR Denial Date:	10/07/2013
Priority:	Standard	Application Received:	10/15/2013

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, has a subspecialty in Pulmonary Disease 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 44-year-old male who reported an injury on 01/21/2012. The patient is currently diagnosed with complex regional pain syndrome in the left upper extremity, status post left shoulder arthroscopic surgery in 06/2013, and status post comminuted fracture of the left proximal humerus with delayed union. The patient was seen by [REDACTED] on 12/27/2013. The patient reported ongoing neck pain, left shoulder and left upper extremity symptoms. Physical examination revealed tenderness to palpation in the left cervical paraspinal musculature, positive allodynia, 1+ to 2+ muscle spasm, tenderness to palpation over the left acromioclavicular joint and distal clavicle, positive allodynia in the left deltoid region, scapular region, and biceps, 1+ swelling with mild erythema and slight mottling of the skin with increased warmth to touch compared to the right upper extremity, and 50% decreased range of motion. Treatment recommendations included continuation of current medications including Norco, Neurontin, amitriptyline, Zofran, tizanidine, and temazepam.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tizanidine 4mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines..

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

Decision rationale: The California MTUS Guidelines state that muscle relaxants are recommended as nonsedating second-line options for short term treatment of acute exacerbations in patients with chronic low back pain. Efficacy appears to diminish over time, and prolonged use may lead to dependence. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain in the neck and left upper extremity. The patient's physical examination continues to reveal palpable muscle spasm. As guidelines do not recommend long term use of this medication, the current request is not medically appropriate. Therefore, the requested Tizanidine is not medically necessary or appropriate.

Zofran 4mg #30: 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) Chronic Pain Chapter, Ondansetron, Antiemetics.

Decision rationale: The Official Disability Guidelines state that ondansetron (Zofran) is not recommended for nausea and vomiting secondary to chronic opioid use. Ondansetron is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment, and has been approved for postoperative use. The patient does not currently meet criteria as outlined by the Official Disability Guidelines for the use of this medication. Therefore, the requested Zofran is not medically necessary or appropriate.

Restoril 50mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines. Page(s): 24.

Decision rationale: The California MTUS Guidelines state that benzodiazepines (Restoril) are not recommended for long term use, because long term efficacy is unproven and there is a risk of dependence. As per the clinical documentation submitted, the patient was issued a prescription for temazepam for insomnia on a non-industrial basis. The patient has also previously utilized Lunesta and Ambien. Despite ongoing use of this medication, there is no evidence of functional improvement. There is no documentation of chronic insomnia or sleep disturbance. There is also no documentation of a failure to respond to nonpharmacological treatment prior to the request for a prescription medication. As the guidelines do not recommend long term use of

benzodiazepines, the current request is not medically appropriate. Therefore, the requested Restoril is not medically necessary or appropriate at this time.