

<b>Case Number:</b>	CM13-0062088		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	12/15/2002
<b>Decision Date:</b>	04/07/2014	<b>UR Denial Date:</b>	11/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/06/2013

### 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 Pain Medicine, and is licensed to practice in Texas. 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 51-year-old female who reported an injury on 12/15/2002. The mechanism of injury was not specifically stated. The patient is diagnosed with left shoulder impingement syndrome, cervical strain/sprain, cervical discopathy, status post lumbar disc displacement, lumbar discopathy with radiculopathy, carpal tunnel syndrome, and lumbar facet syndrome. The patient was seen by [REDACTED] on 10/18/2013. The patient reported ongoing neck, low back, and right shoulder pain. Physical examination revealed tenderness with spasm and tightness of the cervical spine, weakness, mild tenderness with spasm and tightness of the lumbar spine, and weakness in end range. Treatment recommendations included a urine sample and continuation of current medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**AMBIEN 10 MG, #30:** 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:** Decision based on MTUS Chronic Pain Treatment Guidelines Insomnia Treatment.. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG),

**Decision rationale:** The MTUS Guidelines indicate 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 to 10 days. According to the documentation submitted, there is no evidence of chronic insomnia or sleep disturbance. There is also no evidence of a failure to respond to non-pharmacologic treatment prior to the initiation of a prescription product. The employee has continuously utilized this medication. Documentation of functional improvement was not provided. Based on the clinical information received and the Official Disability Guidelines, the request is non-certified.

**HYDROCODONE/APAP 10/325 MG, #60:** Upheld

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

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

**Decision rationale:** The MTUS Guidelines indicate that a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The employee has continuously utilized this medication. Despite ongoing use, the employee continues to report persistent pain over multiple areas of the body. Satisfactory response to treatment has not been indicated. Therefore, the request is non-certified.

**COLACE 100 MG, #30:** 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:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Page(s): 77. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Opioid Induced Constipation Treatment.

**Decision rationale:** The MTUS Guidelines indicate that prophylactic treatment of constipation should be initiated when also initiating opioid therapy. The Official Disability Guidelines indicate that opioid-induced constipation treatment is recommended. First-line treatment includes increasing physical activity, maintaining appropriate hydration, and advising the patient to follow a proper diet. According to the documentation submitted, there is no evidence of chronic constipation or gastrointestinal complaints. There is also no evidence of a failure to respond to first-line treatment. Based on the clinical information received, the request is non-certified.

**FLURIFLEX CREAM (FLURBIPROFEN 15%/CYCLOBENZAPRINE 10%), #180:**  
Upheld

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

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

**Decision rationale:** The MTUS Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of anticonvulsants and antidepressants have failed. According to the documentation submitted, there is no evidence of a failure to respond to first-line oral medication. Additionally, muscle relaxants are not recommended as there is no evidence for the use of any muscle relaxant as a topical product. Therefore, the request is non-certified.

**TGICE CREAM (TRAMADOL 8%, GABAPENTIN 10%, MENTHOL 2%, CAMPHOR 2%, CAPSAICIN 0.05%) #180:** Upheld

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

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

**Decision rationale:** The MTUS Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of anticonvulsants and antidepressants have failed. There is no documentation of a failure to respond to first-line oral medication prior to the initiation of a topical analgesic. Furthermore, gabapentin is not recommended as there is no evidence for the use of any anti-epilepsy drug as a topical product. Therefore, the request is non-certified.

**RETRO -- URINALYSIS:** 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:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43 77 and 89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Urine Drug Testing.

**Decision rationale:** The MTUS Guidelines indicate that drug testing is recommended as an option, using a urine drug screen to assess for the use or presence of illegal drugs. Official Disability Guidelines indicate that the frequency of urine drug testing should be based on documented evidence of risk stratification, including the use of a testing instrument. The employee's injury was greater than 11 years ago to date, and there is no indication of non-compliance or misuse of medication. There is no evidence that this employee falls under a high-risk category that would require frequent monitoring. Based on the clinical information received, the request is non-certified.

