

Case Number:	CM13-0065347		
Date Assigned:	01/03/2014	Date of Injury:	08/18/1999
Decision Date:	05/19/2014	UR Denial Date:	12/04/2013
Priority:	Standard	Application Received:	12/13/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and Pain Medicine and is licensed to practice in Texas and Ohio. 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 expert 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 injured worker is a 50-year-old female who reported an injury on 08/18/1999. The mechanism of injury was cumulative trauma. Documentation of 10/25/2013 revealed the injured worker had moderate neck pain and mild to moderate low back pain. The injured worker had bilateral upper extremity radiculopathy and complained of aching pain to the left shoulder. It was indicated the injured worker was taking aquatic therapy and medications. The injured worker's diagnoses indicate cervical discopathy/stenosis, bilateral upper extremity overuse tendonitis, anxiety, and depression. The treatment plan included a cervical pillow, a prescription for Norco, Xanax, Voltaren gel, and Zolpidem (Ambien).

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO 10/325MG #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids For Chronic Pain Page(s): 79-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications For Chronic Pain and Ongoing Management Page(s): 60,78.

Decision rationale: The California MTUS Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of an objective improvement in function, objective

decrease in pain, and evidence the patient is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication for greater than 1 year. There was lack of documentation indicating the above criteria. The request as submitted failed to provide the frequency for the requested medication. Given the above, the request for Norco 10/325 #120 is not medically necessary.

XANAX 1MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

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

Decision rationale: The California MTUS Guidelines do not recommend benzodiazepines as treatment for patients with chronic pain for longer than 3 weeks due to a high risk of psychological and physiologic dependency. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication since 2012. There was lack of documentation of the efficacy of the medication. Continued use would not be supported. The request as submitted failed to indicate the frequency for the medication. Given the above, the request for Xanax 1 mg #60 is not medically necessary.

AMBIEN 10MG #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), Pain, Zolpidem (Ambien).

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

Decision rationale: Official Disability Guidelines indicate Zolpidem (Ambien) is appropriate for the short-term treatment of insomnia, generally 2 - 6 weeks. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication for greater than 1 year. There was lack of documentation of the efficacy of the requested medication. There was lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Ambien 10 mg #30 is not medically necessary.

VOLTAREN GEL 4GM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Diclofenac (Voltaren), Page(s): 112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel Page(s): 111.

Decision rationale: The California MTUS states Voltaren® Gel 1% (Diclofenac) is an FDA-approved agent indicated for relief of osteoarthritis pain in joints that lends themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The clinical documentation submitted for review failed to indicate the injured worker had osteoarthritis. There was a lack of documentation of the efficacy of the requested medication. The duration could not be established through supplied documentation. The request as submitted failed to indicate the frequency for the medication. Given the above, the request for Voltaren gel 4 g is not medically necessary.