

<b>Case Number:</b>	CM13-0068058		
<b>Date Assigned:</b>	01/08/2014	<b>Date of Injury:</b>	02/29/2004
<b>Decision Date:</b>	06/06/2014	<b>UR Denial Date:</b>	11/15/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/22/2013

### 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 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 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 49-year-old male who reported an injury on February 9, 2004, secondary to unknown mechanism of injury. The diagnoses included right shoulder pain status post rotator cuff repair, right wrist, forearm and elbow tendonitis, right carpal tunnel and cubital tunnel syndrome, insomnia and upper back and thoracic strain. The injured worker was evaluated on October 17, 2013 for reports of right shoulder pain, right wrist, elbow and hand pain, mid and upper back pain, anxiety, depression and insomnia. The exam noted the injured worker's mood and affect were mildly depressed. The thoracic spine exam noted tenderness to T3-T7 with spasm and range of motion at 60% of normal for flexion and 80% of normal for rotation bilaterally. The treatment plan included physical therapy, continued medication therapy, heat patches and continued home exercise program. The request for authorization was not found in the documentation provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**XANAX 0.5 MG X ONE-MONTH SUPPLY:** 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 Chronic Pain Medical Treatment Guidelines, do not recommend Xanax for long-term use. The injured worker has been prescribed Xanax since at least April 2, 2013. This time frame exceeds the recommended time to be considered short-term use. In addition, the request does not include a specific quantity. The request for Xanax 0.5, one month supply, is not medically necessary or appropriate.

**THERMA HEAT PATCH:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Upper Back And Neck Chapter, Heat Therapy.

**Decision rationale:** The Official Disability Guidelines recommend heat therapy for upper back pain. The injured worker had complaints of upper back pain, however there is no indication of the number of patches requested. The request for Therma heat patch is not medically necessary or appropriate.