

Case Number:	CM13-0068262		
Date Assigned:	01/03/2014	Date of Injury:	06/23/2011
Decision Date:	04/21/2014	UR Denial Date:	12/05/2013
Priority:	Standard	Application Received:	12/19/2013

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 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 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 patient is a 47 year-old patient who reported an injury on 06/23/2011. The mechanism of injury involved repetitive work activity. The patient is currently diagnosed with right shoulder tear, left shoulder tear, stress, and cervical musculoligamentous injury. The patient was seen by [REDACTED] on 10/23/2013. The patient reported intermittent sharp pain in the cervical spine with radiation, numbness, and stiffness. The patient also reported intermittent pain in bilateral shoulders with radiation and numbness. Physical examination revealed tenderness to palpation with limited range of motion. Treatment recommendations included continuation of current medications including Flexeril, Prilosec, Ambien, and 2 compounded creams.

IMR ISSUES, DECISIONS AND RATIONALES

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

GABACYCLTRAM 10%, 6%, 1%, CREAM (15 DAYS) QTY: 60.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety.

Gabapentin is not recommended. Cyclobenzaprine is not recommended. There is no documentation of a failure to respond to first line oral medications prior to the request for a topical analgesic. As guidelines do not recommend antiepilepsy drugs or muscle relaxants as a topical product, the current request cannot be determined as medically appropriate. Therefore, the request is non-certified.

FLURBIP (NAP) CREAM-LIDAMIT 10%, 5%, 5%, CREAM (30 DAYS) QTY: 120.00:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The only FDA approved topical NSAID is diclofenac. Lidocaine is indicated for neuropathic or localized peripheral pain after there has been evidence of a trial of first line therapy. As per the documentation submitted, there is no evidence of a failure to respond to first line oral medication. Guidelines do not recommend Lidoderm in the form of a cream, lotion, or gel. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.

AMBIEN 10 MG QTY: 30.00: 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 (Chronic), 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) Chronic Pain Chapter, Insomnia Treatment

Decision rationale: Official Disability Guidelines state 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. As per the documentation submitted, the patient has continuously utilized this medication. However, there is no evidence of chronic insomnia or sleep disturbance. There is also no documentation of objective functional improvement as a result of the ongoing use of this medication. Based on the clinical information received, the request is non-certified.

FLEXERIL 5 MG QTY: 90.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 64-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 64-66.

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain, numbness, and stiffness. There was no evidence of palpable muscle spasm or spasticity upon physical examination. As guidelines do not recommend long-term use of this medication, the current request is non-certified.

PRILOSEC 20 MG QTY: 60.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular risk Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & Cardiovascular risk Page(s): 68-69.

Decision rationale: California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. As per the documentation submitted, there is no indication of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the patient does not meet criteria for the requested medication. As such, the request is non-certified.