

<b>Case Number:</b>	CM13-0072726		
<b>Date Assigned:</b>	01/17/2014	<b>Date of Injury:</b>	06/30/2009
<b>Decision Date:</b>	04/28/2014	<b>UR Denial Date:</b>	11/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/31/2013

### 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 & Rehabilitation 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 56 year old female who was injured on 06/30/2009 while she sustained multiple physical injuries due to constant running, playing, moving furniture, lifting and holding children and getting knocked over. Prior treatment history has included surgery for a herniated disc in 2009. She also underwent a sleep study dated 03/29/2012. Diagnostic studies reviewed include X-rays of the right wrist and ankles dated 09/09/2010 within normal limits. X-ray of the cervical spine dated 09/09/2010 showed loss of disc height at the C5-C6 level. X-rays of the lumbar spine were unremarkable. MRI of the lumbar spine dated 11/23/2010 revealed a bulge on the L5-S1 and L4-L5 with no canal stenosis. On 12/19/2013 the following tests were performed: 1. X-rays of the lumbar spine revealing mild to moderate Spondylitic change of the disc space and posterior elements at L5-S1 greater than L4-L5, greater than L3-L4. On oblique views the pars inter-articularis are intact. On flexion/extension there is no evidence of saggital instability at any level seen. 2. X-rays of the cervical spine reveal moderate Spondylitic change of the disc spaces at C4-C5 and C5-C6. There is a 2 mm of fixed retrolisthesis of C4 on C5 noted. Oblique views there are minimal narrowing of the C4-C5, C5-C6 neural foramen bilaterally. On flexion/extension laterals, there is no evidence of saggital instability at any levels seen. 3. X-ray right shoulder revealed a slightly down sloping acromion process. There are mild degenerative changes of the acromioclavicular joint. The Glenohumeral joint is unremarkable. There are no peri-articular ossifications or calcifications seen. 4. X-ray of the left shoulder reveals a slightly down sloping acromion process. There are mild degenerative changes of the acromioclavicular joint. There are no particular ossifications or calcifications seen. Pr-2 dated 09/12/2013 documented the patient to have complaints of her cervical spine bothering her more of late than any other body part. She states her pain level is a 5. Objective findings on exam revealed she has stiffness and weakness in her bilateral shoulders. PR-2 dated 11/18/2013 documented the patient

stating that she continues to struggle a bit and seems to be running into trouble obtaining proper information from the doctor she needs. She will discuss previous doctor's requests today during her office visit. Objective findings on exam reveal anterior tenderness with numbness and stiffness in the bilateral shoulders as well as loss of strength in the internal and external rotation. Her pain is level 5.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**BIO-THERM 120 MG:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://www.totalbeauty.com/reviews/brands/biotherm> [http://www.biotherm-usa.com/on/demandware.store/Sites-Biotherm\\_US-Site/default/Home-Show?site=1](http://www.biotherm-usa.com/on/demandware.store/Sites-Biotherm_US-Site/default/Home-Show?site=1)

**Decision rationale:** The medical records do not specify what this product is, or how it is anticipated to improve or address this patient's industrial injury. An Internet web search of the name indicates Bio Therm is a brand name for a line of luxury skincare products. The medical necessity of this product has not been established, and is recommended as non-certified.

**THERAFLEX 180 MG 20% / 10% / 4%::** Upheld

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

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

**Decision rationale:** The CA MTUS guidelines state topical analgesics are considered largely experimental in use with few randomized controlled trials to determine efficacy or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. However, there is little to no research to support the use of many of these agents. The submitted medical records do not clearly document the contents of this topical product. In absence of this documentation, the medical necessity of the request cannot be established. Internet search indicates this product contains methyl Salicylate and several other components in a proprietary blend. This product does not appear to have FDA approval. The guidelines state only FDA-approved products are currently recommended. In addition, the medical records do not substantiate the patient is unable to tolerate oral medications, which would be considered standard first-line intervention. The medical necessity of Theraflex has not been established, and this request is not certified.

**AMBIEN 10 MG, #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), Pain Section, Insomnia; Insomnia Treatment

**Decision rationale:** Review of the medical records does not reveal subjective report of sleep difficulties. The medical records submitted do not document any subjective complaints or corroborative clinical objective findings as to establish an active diagnosis of insomnia. According to the referenced guidelines, Ambien is indicated short-term treatment of insomnia, however, as the diagnosis of insomnia is not evident, the medical necessity of Ambien 10mg #30 has not been established, and the request is not certified.