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| Case Number: | CM14-0008047 | | |
| Date Assigned: | 02/12/2014 | Date of Injury: | 11/26/2012 |
| Decision Date: | 06/24/2014 | UR Denial Date: | 01/07/2014 |
| Priority: | Standard | Application Received: | 01/22/2014 |

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 Anesthesiology and is licensed to practice in Massachusetts, New Jersey, Connecticut and 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 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 61 year old male who sustained an injury on 11/26/12. No specific mechanism of injury was noted. The injured worker was followed for multiple complaints including neck pain low back pain radiating pain in the upper extremities and lower extremities. The injured worker had prior arthroscopic rotator cuff repair for the left shoulder on 04/16/13. The injured worker was followed for pain management by [REDACTED]. The patient's medications included Ambien, Duragesic, Norco, Neurontin, and Flexeril. A previous urine drug screen findings showed inconsistent findings for Fentanyl which had a negative result. These were confirmatory studies. The injured worker was seen on 12/26/13 for continuing complaints of neck pain and low back pain. The injured worker reported quality of sleep was poor. The injured worker reported that medications were no longer effective. The injured worker was asking for epidural steroid injections for both cervical spine and lumbar spine to alleviate pain. Physical examination noted limited range of motion in the cervical spine and lumbar spine with tenderness to palpation. No motor weakness was identified however there was some decreased sensation to light touch in C8-T1 left distribution and left L4 through S1 distribution. A PR2 report from 02/14/14 indicated the injured worker had persistent low back pain. It was unclear what medications were currently being prescribed to the injured worker at this evaluation. Physical examination noted continuing limited range of motion in the shoulder. The requested Ambien 10mg quantity 30 and Flexeril 10mg quantity 60 were denied by utilization review on 01/07/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

AMBIEN 10 MG TAB TAKE 1 AS NEEDED QTY 30: Upheld

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

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: In regards to the request for Ambien 10mg quantity 30, this medication is not medically necessary based on clinical documentation submitted for review and current evidence based guidelines. The clinical documentation did not identify any substantial benefits being provided by Ambien as of December of 2013. Per this report, the injured worker reported no relief from any of the prescribed medications. Given the lack of any efficacy from the use of Ambien, and as this medication is not recommended for long term use, this request is not medically necessary or appropriate.

FLEXERIL 10 MG TAKE 1 TWICE DAILY QTY 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxant Page(s): 63-67.

Decision rationale: In regards to the request for Flexeril 10mg quantity 60, this medication is not medically necessary based on clinical documentation submitted for review and current evidence based guidelines. The clinical documentation did not identify any substantial benefits being provided by Flexeril as of December of 2013. Per this report, the injured worker reported no relief from any of the prescribed medications. Given the lack of any efficacy from the use of Flexeril, and as this medication is not recommended for long term use, this request is not medically necessary.