

Case Number:	CM14-0014677		
Date Assigned:	04/09/2014	Date of Injury:	12/02/2009
Decision Date:	05/08/2014	UR Denial Date:	01/27/2014
Priority:	Standard	Application Received:	02/05/2014

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 Family Practice, 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 injured worker is a 62-year-old female who reported an injury on 12/20/2009. The mechanism of injury was not provided. Current diagnoses include status post bilateral shoulder acromioplasty, history of cervical sprain, history of lumbar sprain, history of bilateral carpal tunnel syndrome, gastroesophageal reflux disease (GERD) and history of anxiety and depressive disorder. The injured worker was evaluated on 09/02/2013. The injured worker reported persistent low back pain with radiation to the right lower extremity. Current medications include Valium, Voltaren gel, Celebrex, and Vicodin. The injured worker has also been previously treated with myofascial release therapy. Physical examination revealed limited lumbar range of motion, intact sensation and motor strength, positive Phalen's and Tinel's testing bilaterally, sensory loss over the median nerve distribution bilaterally, limited cervical range of motion, and full, active range of motion of bilateral shoulders with positive impingement sign. Treatment recommendations included continuation of current medications as well as 8 myofascial release therapy visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

VALIUM 10MG, #30: Upheld

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

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

Decision rationale: The MTUS Chronic Pain Guidelines state benzodiazepines are not recommended for long-term use, because long-term efficacy is unproven and there is a risk of dependence. There is no documentation of objective functional improvement as a result of the ongoing use of this medication. Additionally, the MTUS Chronic Pain Guidelines do not recommend long-term use of this medication. Therefore, the request is not medically necessary and appropriate.

AMBIEN 10MG, #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC ODG Treatment Integrated Treatment/Disability Duration Guidelines Pain (Chronic) page 142

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, section on Insomnia

Decision rationale: The 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. There is no documentation of chronic insomnia or sleep disturbance in the medical records provided for review. There is also no evidence of a failure to respond to nonpharmacologic treatment. There is no frequency listed in the current request. Based on the clinical information received, the request is not medically necessary and appropriate.

MASSAGE THERAPY WITH A CERTIFIED THERAPIST QTY: 8: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60.

Decision rationale: The MTUS Chronic Pain Guidelines state massage therapy is recommended as an option. This treatment should be an adjunct to other recommended treatment and should be limited to 4 to 6 visits in most cases. The current request for 8 sessions of massage therapy exceeds the MTUS Chronic Pain Guidelines' recommendations. There is also no evidence of objective functional improvement following an initial course of massage therapy. Based on the clinical information received and the MTUS Chronic Pain Guidelines, the request is not medically necessary and appropriate.