MAXIMUS Federal Services

| Case Number: | CM14-0018575 | | |
|---|---|---|---|
| Date Assigned: | 04/18/2014 | Date of Injury: | 03/11/2007 |
| Decision Date: | 06/30/2014 | UR Denial Date: | 01/30/2014 |
| Priority: | Standard | Application Received: | 02/13/2014 |

## 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 Occupational Medicine 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 claimant is a represented [redacted] employee who has filed a claim for chronic neck pain, mid back pain, low back pain, and knee pain reportedly associated with an industrial injury of March 11, 2007. Thus far, the claimant has been treated with the following: Analgesic medications; including long and short acting opioids; sleep aids; topical agents; laxatives; unspecified amounts of aquatic therapy; an earlier left knee meniscectomy in 2009; unspecified number of epidural steroid injections; and extensive periods of time off of work. In a utilization review report dated January 30, 2014, the claims administrator approved request for long-acting morphine, Norco, and Motrin while denying request for Ambien, Colace, and Biofreeze tubes. Prilosec was partially certified and Wellbutrin was also certified. The applicant's attorney appealed the denial. It was acknowledged that the applicant was not working. In a January 6, 2014 progress note, the applicant was described as reporting highly variable 4-8/10 pain. The applicant states that the usage of medications allowed her to work for exercise, go about activities of daily living, perform light household chores, and do cooking, cleaning, laundering, and self-hygiene. The applicant was given renewals of morphine, Norco, Ambien, Colace, Prilosec, and Wellbutrin. The applicant was asked to try home exercises. The applicant was described as having retired from the workplace.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**RETROSPECTIVE REQUEST FOR PRESCRIPTION OF AMBIEN 5MG #60**
**DOS:1/6/14:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment For Workers' Compensation (ODG-TWC), 2012, on the Web (www.odgtreatment.com). Work Loss Data Institute (www.worklossdata.com), Updated 2/14/12

**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, zolpidem.

**Decision rationale:** No, the request for Ambien was not medically necessary, medically appropriate, or indicated here. The MTUS does not address the topic. As noted in ODG Chronic Pain Chapters zolpidem topic, zolpidem or Ambien is recommended in the short-term treatment of insomnia, typically on the order of two to six weeks. It is not recommended for the chronic, long-term, and/or scheduled use purpose for which is being purposed here. No applicant's specific rationale, narrative, or commentary was provided which would offset the unfavorable ODG recommendation. Therefore, the request was not medically necessary.

**RETROSPECTIVE REQUEST FOR PRESCRIPTION OF COLACE 100MG #270**
**DOS:1/6/14:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77.

**Decision rationale:** The request for Colace, conversely, is medically necessary, medically appropriate, and indicated here. As noted on page 77 of the MTUS Chronic Pain Medical Treatment Guidelines, prophylactic treatment for constipation should be initiated in applicant's using opioids chronically. In this case, the applicant is using two opioids chronically, morphine and Norco. Provision of a laxative/stool softener, Colace, is prophylactically indicated, as noted on page 77 of the MTUS Chronic Pain Medical Treatment Guidelines. Therefore, the request was medically necessary.

**RETROSPECTIVE REQUEST FOR PRESCRIPTION OF PRILOSEC 20MG #60**
**DOS:1/6/14:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS & CARDIOVASCULAR RISK.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms, and Cardiovascular Risk Page(s): 69.

**Decision rationale:** The request for Prilosec was not medically necessary, medically appropriate, or indicated here. While page 69 of the MTUS Chronic Pain Medical Treatment

Guidelines does support provision of proton-pump inhibitor such as Prilosec to combat NSAID-induced dyspepsia, in this case, however, there was no mention of the applicant's having issues with dyspepsia, reflux, or heartburn on January 6, 2014 office note in question, either NSAID induced or stand-alone. An earlier note of November 12, 2013 likewise did not mention any issues with dyspepsia, reflux, and/or heartburn. Therefore, the request was not medically necessary.

**RETROSPECTIVE REQUEST FOR PRESCRIPTION OF BIOFREEZE TUBES #2 DOS:1/6/14:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment For Workers' Compensation, 2012, On The Web (www.odgtreatment.com). Work Loss Data Institute (www.worklossdata.com), Updated 2/14/12

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299.

**Decision rationale:** The request for Biofreeze tubes, conversely, was medically necessary, medically appropriate, and indicated here. As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, Table 12-5, simple, low-tech at-home local applicants of heat and cold are considered part and parcel of self-care methods of symptom control for low back pain complaints. In this case, the applicant does have ongoing low back pain complaints. The Biofreeze gel tubes in question do represent simple, low-tech applications of cold therapy. This is indicated, appropriate, and supported by ACOEM as part and parcel of self-care. Therefore, the request was medically necessary.