

Case Number:	CM14-0162145		
Date Assigned:	10/07/2014	Date of Injury:	10/22/2010
Decision Date:	11/10/2014	UR Denial Date:	09/17/2014
Priority:	Standard	Application Received:	10/02/2014

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 Medicine and is licensed to practice in Texas, Ohio and Florida. 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 56 year old female who reported an injury on 10/22/2009. The mechanism of injury was not submitted for clinical review. Her diagnoses include shoulder joint pain and disorder of bursa of shoulder region. Her past treatments included electrotherapy, surgery, medications, and therapy. The diagnostic findings were not included for clinical review. In 2013 the injured worker underwent right shoulder replacement. The injured worker complains that her pain to her right shoulder radiates to her scapula. She describes her average pain as intermittently dull and sharp rated at a 4/10 in severity. She has stated that the cyclobenzaprine decreased her pain by 50%. Upon physical examination on 09/09/2014, it was noted the injured worker had swelling, stiffness, and tenderness in her right shoulder. It was also noted there was intermittent tingling in the right hand and loss of motor control of the upper extremities particularly due to the tingling. The medications regimen included Ambien, and cyclobenzaprine. The treatment plan was noted as continuation with the medications she had been taking. A request was received for Ambien 10mg and Cyclobenzaprine 10mg for continued pain relief and improved function. The Request for Authorization Form was not submitted for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10mg #30 with 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY 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, Zolpidem (Ambien)

Decision rationale: The Official Disability Guidelines note Zolpidem is a prescription short-acting non-benzodiazepine hypnotic, which was approved for the short-term, usually two to six weeks, treatment of insomnia. There is lack of documentation indicating the efficacy of the medication as evidenced by significant objective functional improvement. The request submitted failed to provide the frequency of the medication. As such, the request for Ambien 10mg #30 with 1 refill is not medically necessary and appropriate.

Cyclobenzaprine 10mg #30 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS Page(s): 63-64.

Decision rationale: The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. The guidelines note the medication is not recommended to be used for longer than 2-3 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore the request of Cyclobenzaprine 10mg #30 with 2 refills is not medically necessary and appropriate.