

<b>Case Number:</b>	CM14-0172365		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	08/23/2001
<b>Decision Date:</b>	12/02/2014	<b>UR Denial Date:</b>	10/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/17/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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 47 years old female with an injury date on 08/23/2014. Based on the 07/17/2014 progress report provided by [REDACTED], the diagnoses are: 1. Cervical myofascial pain 2. Status post right shoulder arthroscopy, subacromial decompression, with residuals, 3. Overuse syndrome, right upper extremity. According to this report, the patient complains of "neck pain and stiffness, with occasional radiation to the shoulders and down the upper extremities." Physical exam reveals tenderness at the posterior cervical and bilateral trapezial musculature. Exam findings remain unchanged for 04/17/2014 report. There were no other significant findings noted on this report. The utilization review denied the request on 10/13/2014. [REDACTED] is the requesting provider, and he provided treatment reports from 04/17/2014 to 07/17/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**AMBIEN 10MG, ONE HS #30 WITH TWO REFILLS:** 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) Chronic Pain

Chapter, Insomnia Treatment, Non-Benzodiazepine sedative-hypnotics (Benzodiazepine-receptor agonists)

**Decision rationale:** According to the 07/17/2014 report by [REDACTED] this patient presents with "neck pain and stiffness, with occasional radiation to the shoulders and down the upper extremities." The treater is requesting Ambien 10mg, one HS #30 with 2 refills. The MTUS and ACOEM Guidelines do not address Ambien; however, ODG Guidelines states that zolpidem (Ambien) is indicated for short-term treatment of insomnia with difficulty of sleep onset 7 to 10 days. A short course of 7 to 10 days may be indicated for insomnia; however, the treater is requesting 10mg #30. In this case, medical records indicate the patient has been prescribed Ambien since 04/17/2014 and there were no mentions that the patient has sleeping issue. The treater does not mention the reason why this medication is been prescribed. Furthermore, the treater does not mention that this is for a short-term use. ODG Guidelines does not recommend long-term use of this medication, recommendation is for denial.

**(LIDOCAINE 5%, FLURBIPROFEN 20%) AP B.I.D. 120GM WITH TWO REFILLS:**  
Upheld

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

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

**Decision rationale:** According to the 07/17/2014 report by [REDACTED] this patient presents with "neck pain and stiffness, with occasional radiation to the shoulders and down the upper extremities." The treater is requesting Lidocaine 5%, Flurbiprofen 20% AP B.I.D 120gm with 2 refills. Regarding topical NSAIDs, MTUS states: this class in general is only recommended for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). In this case, the patient does not meet the indication for the topical medication as she does not present with peripheral joint osteoarthritis/tendinitis problems for which topical NSAIDs are indicated. Furthermore, Lidocaine is not recommended in any formulation other than in a patch formulation. Recommendation is for denial.

**ZANAFLEX 2MG ONE BID #60 WITH TWO REFILLS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASTICITY/ANTISPASMODIC DRUGS Page(s): 66.

**Decision rationale:** According to the 07/17/2014 report by [REDACTED] this patient presents with "neck pain and stiffness, with occasional radiation to the shoulders and down the upper extremities." The treater is requesting Zanaflex 2mg one BID #60 with 2 refills. Zanaflex, a muscle relaxant was first noted in the 04/17/2014 report. MTUS guidelines do support Zanaflex

for chronic low back pain, myofascial pain and fibromyalgia pains. In this case, given the patient's chronic pain, use of this medication may be indicated. However, the treater does not explain how this medication is being used with what effectiveness. The MTUS guidelines page 60 require documentation of medication efficacy when it is used for chronic pain. Given the lack of such documentation, recommendation is for denial.