

Case Number:	CM14-0173452		
Date Assigned:	10/24/2014	Date of Injury:	01/31/2006
Decision Date:	12/03/2014	UR Denial Date:	10/13/2014
Priority:	Standard	Application Received:	10/21/2014

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, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 41-year-old female with a 1/31/06 date of injury. At the time (9/24/14) of request for authorization for Zanaflex 4mg (Dispensed 09/24/14), Ambien 5mg (Dispensed 09/24/14), Biofreeze Roll-Ons (Dispensed 09/24/14), and Neck Pillow, there is documentation of subjective (persistent neck, left shoulder and left upper extremity pain and neck spasms) and objective (tenderness to palpitation over the cervical paraspinal muscles extending to the left trapezius and left occipital protuberance) findings, current diagnoses (bilateral carpal tunnel syndrome, protruding disc toward the left at C6-C7, left C7 radiculopathy, and status post left shoulder arthroscopic lysis of adhesion), and treatment to date (TENS unit, Massage, ongoing treatment with Biofreeze Roll-on, and medications (including ongoing treatment with Norco, Zanaflex, and Ambien since at least 2/5/14)). Medical records identify a decrease in pain level as a result of Norco and Zanaflex use, the patient getting 6-7 hours of sleep with the use of Ambien, and that a neck pillow request is for the patient to use at night for sleep. Regarding Zanaflex 4mg, there is no documentation of Zanaflex used as a second line option for short-term (less than two weeks) treatment of acute low back pain or for short-term treatment of acute exacerbations in patients with chronic low back pain, and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Zanaflex use to date. Regarding Ambien 5mg, there is no documentation of Insomnia and short-term (less than two to six weeks) treatment. Regarding Biofreeze Roll-Ons, there is no documentation of trials of antidepressants and anticonvulsants have failed and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Biofreeze Roll-Ons to date. Regarding Neck Pillow, there is no documentation that the neck support pillow will be used in conjunction with daily exercise.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zanaflex 4mg (Dispensed 09/24/14):: 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 (Tizanidine (Zanaflex)) Page(s): 66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain) Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of spasticity, as criteria necessary to support the medical necessity of Tizanidine. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended as a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Within the medical information available for review, there is documentation of diagnoses of bilateral carpal tunnel syndrome, protruding disc toward the left at C6-C7, left C7 radiculopathy, and status post left shoulder arthroscopic lysis of adhesion. In addition, there is documentation of spasticity. However, there is no documentation of Zanaflex used as a second line option. In addition, given documentation of records reflecting prescription for Zanaflex since at least 2/5/14, there is no documentation of short-term (less than two weeks) treatment. Furthermore, despite documentation of persistent neck, left shoulder and left upper extremity pain, there is no documentation of acute low back pain or acute exacerbations in patient with chronic low back pain. Lastly, given documentation of ongoing treatment with Zanaflex and despite documentation of a decrease in pain level as a result of Norco and Zanaflex use, there is no (clear) documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Zanaflex use to date. Therefore, based on based on guidelines and a review of the evidence, the request for Zanaflex 4mg (Dispensed 09/24/14) is not medically necessary.

Ambien 5mg (Dispensed 09/24/14): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Ambien

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 Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS does not address this issue. ODG identifies Ambien (zolpidem) as a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of bilateral carpal tunnel syndrome, protruding disc toward the left at C6-C7, left C7 radiculopathy, and status post left shoulder arthroscopic lysis of adhesion. In addition, given documentation of ongoing treatment with Ambien and the patient is getting 6-7 hours of sleep with the use of Ambien, there is no documentation of functional benefit as a result of Ambien use to date. However, there is no documentation of Insomnia. In addition, given documentation of records reflecting prescription for Ambien since at least 2/5/14, there is no documentation of short-term (less than two to six weeks) treatment. Therefore, based on based on guidelines and a review of the evidence, the request for Ambien 5mg (Dispensed 09/24/14) is not medically necessary.

Biofreeze Roll-Ons (Dispensed 09/24/14);: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Cold Therapy

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20; <http://www.drugs.com/drp/biofreeze-pain-relieving-gel.htm>

Decision rationale: An online search identifies that Biofreeze gel is a topical anesthetic used for the temporary relief from minor aches and pains of sore muscles and joints associated with arthritis, backache, strains and sprains. MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain when trials of antidepressants and anticonvulsants have failed, as criteria necessary to support the medical necessity of Biofreeze. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of bilateral carpal tunnel syndrome, protruding disc toward the left at C6-C7, left C7 radiculopathy, and status post left shoulder arthroscopic lysis of adhesion. In addition, there is documentation of neuropathic pain. However, there is no documentation of trials of antidepressants and anticonvulsants have failed. In addition, given documentation of ongoing treatment with Biofreeze Roll-Ons, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Biofreeze Roll-Ons to date. Therefore, based on based on guidelines and a review of the evidence, the request for Biofreeze Roll-Ons (Dispensed 09/24/14) is not medically necessary.

Neck Pillow: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Chronic Neck Pain

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back, Pillow

Decision rationale: MTUS does not address this issue. ODG identifies documentation that the neck support pillow will be used while sleeping, in conjunction with daily exercise, as criteria necessary to support the medical necessity of cervical pillow. Within the medical information available for review, there is documentation of diagnoses of bilateral carpal tunnel syndrome, protruding disc toward the left at C6-C7, left C7 radiculopathy, and status post left shoulder arthroscopic lysis of adhesion. In addition, given documentation that the pillow neck is used at night for sleep, there is documentation that the neck support pillow will be used while sleeping. However, there is no documentation that the neck support pillow will be used in conjunction with daily exercise. Therefore, based on based on guidelines and a review of the evidence, the request for Neck Pillow is not medically necessary.