

Case Number:	CM14-0037479		
Date Assigned:	06/25/2014	Date of Injury:	12/14/2011
Decision Date:	08/05/2014	UR Denial Date:	03/17/2014
Priority:	Standard	Application Received:	03/28/2014

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 and is licensed to practice in Nevada. 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 37 year-old male who was reportedly injured on 12/14/2011. The mechanism of injury is noted as a fall. The most recent progress note, dated 2/18/2014 indicates that there are ongoing complaints of low back pain, bilateral knee pain, and right shoulder pain. The physical examination is handwritten and partially illegible. I am able to decipher right shoulder tenderness to palpation subacromial, acromioclavicular joint, and possibly supraspinatus range of motion flexion to 130, adduction to 40, abduction to 121 internal rotation to 70, external rotation to 55. Positive crepitus, weakness in all planes, lumbar spine tenderness to palpation, paravertebral musculature, bilateral sciatic notch, positive straight leg raise. No current diagnostic studies/imaging studies are available for review. Previous treatment includes lumbar spine surgery, medications to include Xanax, Prilosec, Norco, Ambien, and Wellbutrin. A request had been made for Fexmid 75mg Quantity: 60, consultation with Urologist, cold therapy unit, Ambien 12.5 mg Quantity: 20, and was not certified in the pre-authorization process on 3/17/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fexmid 75mg Quantity: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants for pain Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26, MTUS (Effective July 18, 2009) Muscle relaxants Page(s): 41, 64.

Decision rationale: Flexmid (cyclobenzaprine) is a skeletal muscle relaxant that is recommended for a short course of therapy. Limited mixed-evidence does not allow for a recommendation for chronic use. The California Medical Treatment Utilization Schedule supports the use of skeletal muscle relaxants such as cyclobenzaprine for the short-term treatment of pain, but advises against long-term use. Given the claimant's date of injury in 2011 and clinical presentation which is handwritten and partially illegible, without objective clinical findings on physical exam or documentation of decrease in pain or improvement in function with the use of this medication, this request for continuation of a long-term setting of this medication is deemed not medically necessary.

Consultation with Urologist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Practice Guidelines, page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation - ACOEM Practice Guidelines, 2nd edition, Chapter 7 - Independent Medical Examinations and Consultations, pg 127.

Decision rationale: After reviewing the medical documentation provided, I was unable to identify any subjective complaints, or objective clinical findings in the physical exam of this injured worker that would necessitate a referral to a urologist. At this time, the requested referral to a specialist is deemed not medically necessary pending further supportive documentation.

Cold Therapy Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 561-563. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

Decision rationale: California Medical Treatment Utilization Schedule guidelines do recommend cryotherapy for treatment of postoperative patients to aid with pain relief and swelling for the first several days status post surgery. The duration of use is commensurate with the extent of surgery. After review of the medical documentation provided it is noted the injured worker is status post lumbar surgery in 2013, right shoulder surgery has been requested but not authorized at this time. Note dated 2/18/2014 states the patient was using cryotherapy for the right shoulder lumbar spine, however, current device is not operable. According to current guidelines, this device is recommended for use in the initial post-op phase, or for the treatment of a few (selected) patients who are unable and/or unwilling to tolerate other measures to manage pain. I was unable to identify any of these factors in the medical documentation provided in

order to approve the request for this device. Therefore this request is deemed not medically necessary at this time.

Ambien 12.5mg Quantity: 20: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG -TWC / ODG Integrated Treatment/Disability Duration Guidelines; Pain - (Chronic) - (updated 6/10/14).

Decision rationale: Ambien is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. After review of the medical documentation provided, as well as Official Disability Guideline treatment guidelines, this medication is recommended for short-term use only typically 2-6 weeks. Therefore, the continued use of this medication is deemed not medically necessary.