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| <b>Case Number:</b>   | CM14-0073683 |                              |            |
| <b>Date Assigned:</b> | 07/16/2014   | <b>Date of Injury:</b>       | 09/02/2009 |
| <b>Decision Date:</b> | 09/19/2014   | <b>UR Denial Date:</b>       | 05/08/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 05/20/2014 |

### **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 Medicine and is licensed to practice in Connecticut. 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:

This is a 41 year old female with complaints of neck pain and right upper extremity pain. The date of injury is 9/2/09 and no mechanism of injury is documented. There are subjective findings including neck pain, right upper extremity pain noted. Objective findings include palpable tenderness and trigger point activity throughout the cervical paraspinal musculature extending into the inter-scapular region, pain extending into the right upper extremity, cervical compression to the right, restricted cervical range of motion, decreased sensation over the right C7 and C8 nerve root distribution. Diagnoses were noted to include cervical strain and sprain, cervical herniated nucleus pulposus, cervical radiculopathy, carpal tunnel syndrome bilaterally, right shoulder impingement with tendonitis, s/p shoulder arthroscopy. Treatment to date includes trigger point injections, right shoulder surgery, cervical epidural steroids, medications, and physical therapy. In regards to the requested pharmacologic treatment, a comprehensive strategy for the prescribing of opioids needs to be in place including detailed evaluation of ongoing pharmacologic treatment including drug analgesic efficacy as well as a gross examination of physical function on and off the medication. Muscle relaxants are recommended for episodes of acute low back pain and spasm, for limited duration up to 2 weeks with the highest efficacy occurring in the first 4 days. Voltaren gel is FDA approved for the indication of osteoarthritis and tendonitis of the knee, elbow, and hand. There is little evidence of benefit to the shoulder, neck, or low back. Zolpidem is recommended only for short term treatment of insomnia.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Norco 10/325MG #180:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78.

**Decision rationale:** Per MTUS-Chronic Pain Medical Treatment Guidelines, a comprehensive strategy for the prescribing of opioids needs to be in place including detailed evaluation of ongoing pharmacologic treatment ie drug analgesic efficacy as well as a gross examination of physical function on and off the medication (or at the end of a dosing cycle). Aberrant behavior (or absence of) due to drug misuse (or compliance) needs to be documented. Drug urine testing should be performed. A medication agreement is highly recommended and should be on file. As the medical records provided do not support/supply this information, the request is not medically necessary.

**Flexeril 7.5mg #30:** Overturned

**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:** Per MTUS-Chronic Pain Medical Treatment Guidelines and ODG Guidelines, muscle relaxants are recommended for episodes of acute low back pain and spasm for limited duration up to 2 weeks with the highest efficacy occurring in the first 4 days. As the documentation supports appropriate use of Cyclobenzaprine (Flexeril) as outlined by the requesting physician, the request is medically necessary.

**Volteran gel 4g #480:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111. Decision based on Non-MTUS Citation (ODG) Chronic Pain, Topical Analgesics.

**Decision rationale:** Per MTUS-Chronic Pain Medical Treatment Guidelines and ODG, Voltaren gel is FDA approved for the indication of osteoarthritis and tendonitis of the knee, elbow, and hand. There is little evidence of benefit to the shoulder, neck, or low back. Therefore, this medication is not medically necessary.

**Ambien 10mg #30:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Chronic pain, Zolpidem.

**Decision rationale:** Per ODG Evidence Based Decision Guidelines, Zolpidem is recommended only for short term treatment of insomnia. Therefore, this medication is not medically necessary.