

<b>Case Number:</b>	CM14-0081573		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	09/13/2003
<b>Decision Date:</b>	10/31/2014	<b>UR Denial Date:</b>	05/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/02/2014

### 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 Orthopedic Surgery 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:

This is a 47-year-old female injured in a work-related accident on 09/12/03. The clinical records for review included a progress report dated 04/24/14 describing complaints of pain. The records documented that the claimant was deemed permanent and stationary in relation to chronic complaints to the neck and upper extremities and low back pain radiating to the lower extremities diagnosed as failed low back surgery syndrome status post multiple back surgeries and multilevel surgical degenerative disc disease. Physical examination on 04/24/14 revealed restricted range of motion of the lumbar and cervical spine with moderate spasm, tenderness over the C6 and C7 dermatomal distribution with sensory loss, normal reflexes, and motor weakness to the left extensor hallucis longus in the lower extremity. There was no documentation of right shoulder or left knee pain at the visit. There is also no documentation of previous treatment for the claimant's knee or shoulder for review. The recommendation was made for continued use of medications of Ambien, Oxycodone, Flexeril, Terocin Lotion, and a request for MRI scans of the right shoulder and left knee. In review of the medical records, the current dose of requested Oxycodone is an increase in dosage by greater than sixty pills. There is also documentation of opioid dependence and there is no true documentation in the records that the claimant receives benefit with the medication regimen. In a prior assessment dated 01/21/14, it was documented that Ambien was "ineffective" and that the use of opioids dated back to 2012.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien 10mg #30:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain Chapter: Zolpidem (Ambien®)

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) and American College of Occupational and Environmental Medicine (ACOEM) Guidelines do not provide criteria relevant to this request. Based on the Official Disability Guidelines, the request for Ambien is not recommended as medically necessary. According to the recommendation by the Official Disability Guidelines, the use of Ambien should only be on a short term basis and it does not recommend this shortacting non-Benzodiazepine hypnotic for greater than two to six weeks. Ambien is only indicated for the treatment of insomnia; there is no documentation in the records provided for review that the claimant is diagnosed with insomnia or is being treated for symptoms of insomnia. There is documentation in January 2014, by the treating provider that Ambien was ineffective. Based on the Official Disability Guidelines (ODG) Guidelines and the documentation in the medical records, there would be no indication for prescribing Ambien for this claimant.

**Oxycodone 30mg #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80.

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines would not recommend the continued use of Oxycodone for this claimant. According to the medical records, the dosage of Oxycodone was significantly increased at the time of the last clinical assessment. There is no documentation that the claimant receives any benefit from taking Oxycodone. The claimant is noted to be on serial narcotic use with no demonstration of functional benefit, change in work-related status or activity levels over the past twelve months. Therefore, based on the Chronic Pain Guidelines and the medical records, continued use of Oxycodone cannot be recommended as medically necessary.

**Flexeril 10mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Cyclobenzaprine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics: Cyclobenzaprine Page(s): 63.

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Guidelines also do not support the continued use of Flexeril. According to the recommendation of the Chronic Pain Guidelines, muscle relaxants should be utilized with caution as second line agents in the acute inflammatory setting in the chronic pain setting. While the medical records document that the claimant has chronic pain, there is no documentation of acute clinical findings or symptoms to support the use of this muscle relaxant Flexeril. The continued use of Flexeril on the basis of the claimant's working diagnosis alone would not be indicated.

**Terocin Lotion:** Upheld

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

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

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Guidelines do not support the use of Terocin Lotion. The Chronic Pain Guidelines recommend that topical compounding agents are largely experimental with few randomized clinical trials demonstrating their efficacy or long term benefit. The combination agent of Terocin contains, amongst other agents, Capsaicin and Lidocaine. Both Capsaicin and Lidocaine are only indicated as second line agents in the chronic pain setting. The current use of Terocin as a second line agent would not be supported because there is no documentation of recent treatment with first line agents for neuropathic pain or functional restoration.

**MRI of the right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-9.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 196.

**Decision rationale:** The California American College of Occupational and Environmental Medicine (ACOEM) Guidelines do not recommend an MRI of the right shoulder. The claimant's current presentation indicates pain complaints in the neck and low back with a diagnosis of failed low back syndrome. There is currently no documentation of subjective complaints of right shoulder pain or documentation of objective findings on examination of the right shoulder in the records provided for review to support the need for MRI imaging. The request for an Magnetic resonance imaging (MRI) scan would not be supported.

**MRI of the left knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343, 347. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341.

**Decision rationale:** The California American College of Occupational and Environmental Medicine (ACOEM) Guidelines also do not support the request for a Magnetic resonance imaging (MRI) of the left knee. The claimant's clinical presentation includes neck and low back related complaints. There is no documentation of subjective complaints of left knee pain or formal examination findings of the left knee to support the need for imaging. Without a clinical presentation supporting left knee symptoms, the request in this case would not be indicated as medically necessary.