

Case Number:	CM14-0089529		
Date Assigned:	07/23/2014	Date of Injury:	06/01/2011
Decision Date:	09/03/2014	UR Denial Date:	06/03/2014
Priority:	Standard	Application Received:	06/13/2014

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:

The records presented for review indicate the injured worker is a 65 year old female who was reportedly injured on June 1, 2011. The mechanism of injury is not listed in the records reviewed. The most recent progress note, dated March 27, 2014, indicates there are ongoing complaints of cervical spine and lumbar spine pain. The physical examination demonstrated tenderness of the cervical spine paraspinal muscles with spasms. There was decreased cervical spine range of motion. Neurological examination indicates decreased sensation at C5, C6, and C7 bilaterally. The examination of the lumbar spine noted tenderness of the paraspinal muscles with spasticity. There was also decreased lumbar spine range of motion. The lower extremity neurological examination indicated decreased sensation at L5 and S1 on the left side. Lower extremity muscle strength was 5/5. Diagnostic imaging studies of the lumbar spine indicated a left posterior lateral disc protrusion at L4/L5 and a right-sided posterior lateral disc herniation at L5/S1. Previous treatment includes chiropractic care. A request was made for gabapentin, Ambien, Flurbiprofen/Capsaicin/Menthol/Camphor and Ketoprofen/Cyclobenzaprine/Lidocaine and was not certified in the pre-authorization process on June 3, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 300mg #60: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [Http://www.dir.ca.gov/t8/ch4_5sb1a5_5_2.html](http://www.dir.ca.gov/t8/ch4_5sb1a5_5_2.html)AED.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-20.

Decision rationale: The California MTUS considers gabapentin to be a first-line treatment for neuropathic pain. Based on the clinical documentation provided, there is evidence of neuropathic and radicular pain on exam. As such, the request for Gabapentin is medically necessary.

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: Insomnia Treatment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - TWC/ODG Integrated Treatment/Disability Duration Guidelines; Pain (Chronic) - Ambien (updated 07/10/14).

Decision rationale: According to the Official Disability Guidelines Zolpidem (Ambien) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. The guidelines specifically do not recommend them for long-term use for chronic pain. Additionally, there is no documentation of insomnia or any sleep issues in the recent progress note dated March 27, 2014. As such, this request for Ambien is not medically necessary.

Flurbiprofen/Capsaicin/Menthol/Camphor - 10% / 0.25% / 2% / 1% - 120gm: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.dir.ca.gov/t8/ch4_5sb1a5_5_2.html Topical Analgesics.

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

Decision rationale: According to the California Chronic Pain Medical Treatment Guidelines the only recommended topical analgesic agents are those including anti-inflammatories, Lidocaine, or Capsaicin. There is no peer-reviewed evidence-based medicine to indicate that any other compounded ingredients have any efficacy. For this reason, the request for Flurbiprofen/Capsaicin/Menthol/Camphor is not medically necessary.

Ketoprofen/Cyclobenzaprine/Lidocaine - 10%/ 3% / 5%- 120gm: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.dir.ca.gov/t8/ch4_5sb1a5_5_2.html Topical Analgesics.

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

Decision rationale: According to the California Chronic Pain Medical Treatment Guidelines the only recommended topical analgesic agents are those including anti-inflammatories, Lidocaine, or Capsaicin. There is no peer-reviewed evidence-based medicine to indicate that any other compounded ingredients have any efficacy. For this reason this request for Ketoprofen/Cyclobenzaprine/Lidocaine is not medically necessary.