

Case Number:	CM14-0092042		
Date Assigned:	08/06/2014	Date of Injury:	09/18/2002
Decision Date:	09/30/2014	UR Denial Date:	05/21/2014
Priority:	Standard	Application Received:	06/18/2014

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 Internal Medicine 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 injured worker is a 68 year old female injured on 09/18/02 due to undisclosed mechanism of injury. Diagnoses included chronic pain syndrome/fibromyalgia, cervical spine sprain/strain syndrome, carpal tunnel release, and lumbar facet syndrome. Clinical note dated 01/13/14 indicated the injured worker presented for medication management, renewal of home interferential unit, and non-narcotic analgesic for residual complaints. The injured worker reported interferential unit was helpful. Objective findings included alert and cooperative, and diffuse non-specific axial cervical spine and lumbar spine tenderness. Urine drug screen was negative for opioids consistent with present analgesic regimen. Treatment plan included continuation of Ambien, Tramadol, Lidoderm patches, Flexeril, Biofreeze and continue use of interferential unit. The initial request was non-certified on 05/20/14.

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.

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

Decision rationale: As noted in the Pain (Chronic) of the Official Disability Guidelines (ODG) - online version, Ambien is approved for the short-term (usually two to six weeks) treatment of insomnia. Pain specialists rarely, if ever, recommend it for long-term use. Ambien can be habit-forming, and may impair function and memory more than opioid pain relievers. There is also concern that it may increase pain and depression over the long-term. The injured worker has been utilizing this medication on a long-term basis, exceeding the recommended 2-6 week window of use. As such, the request for Ambien 10mg, #30 cannot be recommended as medically necessary.

Tramadol 50mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. Specific examples of improved functionality should be provided to include individual activities of daily living, community activities, and exercise able to perform as a result of medication use. As such, tramadol 50mg, #60 cannot be recommended as medically necessary at this time.

Lidoderm Patches 5%, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56.

Decision rationale: As noted on page 56 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Lidoderm is recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. There should be evidence of a trial of first-line neuropathy medications (tri-cyclic or serotonin norepinephrine reuptake inhibitor antidepressants or an antiepileptic such as gabapentin or Lyrica). Lidoderm is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. Therefore, the Lidoderm Patches 5%, #90 cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

Flexeril 10mg, #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41.

Decision rationale: As noted on page 41 of the Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine is 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. Studies have shown that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Based on the clinical documentation, the injured worker has exceeded the 2-4 week window for acute management also indicating a lack of efficacy if being utilized for chronic flare-ups. Additionally, the objective findings failed to establish the presence of spasm warranting the use of muscle relaxants. As such, the medical necessity of Flexeril 10mg, #30 cannot be established at this time.

Biofreeze Gel, #1: 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 Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Biofreeze® cryotherapy gel.

Decision rationale: As noted in the Official Disability Guidelines, Biofreeze gel is recommended as an optional form of cryotherapy for acute pain. Biofreeze is a nonprescription topical cooling agent with the active ingredient menthol that takes the place of ice packs. The clinical documentation indicates the intent to use the medication for chronic pain. Additionally, there is no indication the injured worker requires prescribing of a nonprescription topical cooling agent if required on an as needed basis. As such, the request for Biofreeze Gel, #1 cannot be recommended as medically necessary at this time.

Interferential Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118.

Decision rationale: As noted on page 118 of the Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation (ICS) is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments,

including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. There is no indication of intent to utilize in conjunction to therapy, etc. Additionally, the documentation does not discuss the injured worker's work status. As such, the request for Interferential Unit cannot be recommended as medically necessary.