

<b>Case Number:</b>	CM14-0138197		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	04/14/1998
<b>Decision Date:</b>	04/15/2015	<b>UR Denial Date:</b>	07/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/26/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Emergency Medicine

### 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 47 year old female, who sustained an industrial injury on April 14, 1998. She reported falling and sustained multiple injuries. The injured worker was diagnosed as having complex regional pain syndrome type I of left upper extremity including hand, global muscular atrophy secondary to disuse, and chronic back pain status post back surgery. Treatment to date has included medications, imaging, acupuncture, and spinal cord stimulator. Currently, the injured worker complains of increased right side body pain as of September 3, 2014. She reports cramps in her feet with radiation into the calves. She rates her pain as 8-9/10 on a pain scale. She reports having experienced multiple falling episodes from weakness, while trying to improve her function. The providers treatment plan is: Omeprazole 20mg #60, Ambien 12.5mg at bedtime as needed for sleep, Lidoderm patch 32, Oxycontin 20mg #60 every 12 hours, Neurontin 300mg #90 every 8 hours, Norco 10/325mg #90 every 8 hours as needed for pain breakthrough if Oxycontin isn't covering the pain, physical therapy 3 times weekly for one month, Zofran 4mg every 12 hours as needed, laboratory evaluations, and follow-up in 4 weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flexeril 10mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines- Treatment in Workers Compensation, Online Edition Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Page63-66 Page(s): 63-66.

**Decision rationale:** The requested Flexeril 10mg #90 is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Muscle Relaxants, Page 63-66, do not recommend muscle relaxants as more efficacious than NSAIDs and do not recommend use of muscle relaxants beyond the acute phase of treatment. The injured worker has cramps in her feet with radiation into the calves. The treating physician has documented complex regional pain syndrome type I of left upper extremity including hand, global muscular atrophy secondary to disuse, and chronic back pain status post back surgery. The treating physician has not documented duration of treatment, intolerance to NSAID treatment, nor objective evidence of derived functional improvement from its previous use. The criteria noted above not having been met, Flexeril 10mg #90 is not medically necessary.

**Zofran 8mg #90:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment in Workers Compensation, Online Edition Pain Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Ondansetron (Zofran®).

**Decision rationale:** The requested Zofran 8mg #90 is not medically necessary. CA MTUS 2009 ACOEM is silent on this issue. Official Disability Guidelines, Pain (Chronic), Ondansetron (Zofran), note "Not recommended for nausea and vomiting secondary to chronic opioid use." The injured worker has cramps in her feet with radiation into the calves. The treating physician has documented complex regional pain syndrome type I of left upper extremity including hand, global muscular atrophy secondary to disuse, and chronic back pain status post back surgery. The treating physician has not documented symptoms of nausea and vomiting, duration of treatment, nor derived functional improvement from its use. The criteria noted above not having been met, Zofran 8mg #90 is not medically necessary.

**Ambien CR 12.5mg #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- Treatment in Workers Compensation, Online Edition Pain Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), (updated 07/10/14), Insomnia Medications.

**Decision rationale:** The requested Ambien CR 12.5mg #30 is not medically necessary. CA MTUS is silent. Official Disability Guidelines, Pain (Chronic), (updated 07/10/14), Insomnia Medications note "Zolpidem is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia." The injured worker has cramps in her feet with radiation into the calves. The treating physician has documented complex regional pain syndrome type I of left upper extremity including hand, global muscular atrophy secondary to disuse, and chronic back pain status post back surgery. The treating physician has not documented current sleep disturbance, results of sleep behavior modification attempts or any derived functional benefit from its previous use. The criteria noted above not having been met, Ambien CR 12.5mg #30 is not medically necessary.