

<b>Case Number:</b>	CM15-0130114		
<b>Date Assigned:</b>	07/16/2015	<b>Date of Injury:</b>	01/26/2012
<b>Decision Date:</b>	09/10/2015	<b>UR Denial Date:</b>	06/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/06/2015

### 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: New York  
 Certification(s)/Specialty: Anesthesiology

### 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 62 year old female, who sustained an industrial injury on January 26, 2012. She reported slipping and falling with lower back and left wrist problems. The injured worker was diagnosed as having cervical spine disc bulges, thoracic spine disc bulges, lumbar spine disc bulges, right shoulder strain, left shoulder strain, right elbow strain, left elbow strain, right hand/wrist strain, and left wrist/hand strain. Treatments and evaluations to date have included chiropractic treatments, x-rays, acupuncture, and medication. Currently, the injured worker complains of increased cervical spine, lumbar spine, and bilateral shoulder pain. The Secondary Treating Physician's report dated May 21, 2015, was handwritten, difficult to read in parts, noting the injured worker had an Agreed Medical Exam (AME) appointment and was rear-ended on the freeway with increased lower back pain, right greater than left. The Primary Treating Physician's report dated May 26, 2015, noted the injured worker in a motor vehicle accident on May 7, 2015, with an increase in cervical spine, lumbar spine, and bilateral shoulder pain. The injured worker was noted to be able to return to work on May 26, 2015, with sedentary work for six weeks. On May 21, 2015, a request for authorization was made for Ambien, Biofreeze gel, and Skelaxin.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien 10mg #15 with 3 refills:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Insomnia treatment.

**Decision rationale:** Ambien (Zolpidem) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia and is rarely recommended for long-term use. It can be habit-forming, may impair function and memory more than opioid analgesics, and may increase pain and depression over the long-term. The treatment of insomnia should be based on the etiology and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. There is no documentation of duration of prior Ambien use. There is no documentation provided indicating medical necessity for Ambien. The requested medication is not medically necessary.

**Biofreeze gel 3.5% #2 tubes with 3 refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Biofreeze cryotherapy gel.

**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) Chapter, Biofreeze cryotherapy gel.

**Decision rationale:** The MTUS is silent on the use of Biofreeze gel. The Official Disability Guidelines (ODG) notes that Biofreeze cryotherapy gel is a nonprescription topical cooling agent with the active ingredient of menthol, recommended as an option for acute pain. Menthol is not discussed in the MTUS or ODG. The treating physician's request did not include the site of application or directions for use. As such, the prescription is not medically necessary.

**Skelaxin 800mg #60 with 3 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-65.

**Decision rationale:** Metaxalone (Skelaxin) is reported to be a relatively non-sedating muscle relaxant. The exact mechanism of action is unknown, but the effect is presumed to be due to general depression of the central nervous system. A hypersensitivity reaction (rash) has been

reported. It is to be used with caution in patients with renal and/or hepatic failure. Skelaxin is recommended as a second-line option for short-term (less than two weeks) treatment of acute LBP and for short-term treatment of acute exacerbations in patients with chronic LBP. According to the CA MTUS guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. In this case, the documentation supports chronic pain, not acute exacerbations for short periods. In addition, the patient has not shown a documented benefit or any functional improvement from prior Skelaxin use. Medical necessity for this muscle relaxant has not been established. The requested medication is not medically necessary.