

Case Number:	CM15-0083872		
Date Assigned:	05/06/2015	Date of Injury:	10/15/2007
Decision Date:	06/04/2015	UR Denial Date:	04/21/2015
Priority:	Standard	Application Received:	05/01/2015

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: Connecticut, California, Virginia
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 52-year-old female, who sustained an industrial injury on 10/15/07. She has reported initial complaints of right hand tingling from repetitive work and cumulative trauma. The diagnoses have included reflex sympathetic dystrophy of the right upper limb and ulnar neuropathy. Treatment to date has included medications, activity modifications, right radial tunnel release surgery, ulnar nerve transposition, home exercise program (HEP) and Functional Restoration Program. Currently, as per the physician progress note dated 4/9/15, the injured worker complains of right arm pain. It was noted that she has successfully completed a Functional Restoration Program. She now reports that her pain is rated 3-4/10 as opposed to 8-9/10 on pain scale. She now has the ability to use her right arm for more tasks than before. She can withstand touch and pressure now and she no longer experiences the severe temperature changes or burning sensation with touch. She is doing a home exercise program (HEP). She has lost over 20 pounds and her energy level has gone up. She continues to have exacerbations but reports that they are less severe and more manageable with her learned skills. She is not back to work as of yet but is going to look for part time employment and has started to drive again. She is requesting re-fill on her medications and states that the medications help alleviate the pain and assist in her performing her activities of daily living (ADL). The current pain is rated 7/10, the least pain is rated 8/10 and the worst pain is rated 9/10, which is unchanged from previous visit. She describes the pain as stabbing. Physical exam revealed weight is 210 pounds, height is 5 feet 7 inches, BMI is 32.9, and blood pressure is 111/73. The current medications included Norco, Flexeril, Ambien, Lyrica, Naproxen and Vicodin. There was no urine drug screen noted in the

records. The physician requested treatments included Flexeril 10mg, #60 with 1 refill and Ambien 10mg, #30 with 3 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexeril 10mg, #60 with 1 refill: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain); Cyclobenzaprine (Flexeril).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flexeril Page(s): 41-42.

Decision rationale: The MTUS addresses use of Flexeril, recommending it as an option, using a short course of therapy. Flexeril is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Per the MTUS, treatment should be brief. In this case, while treatment has been chronic and acute spasm is not noted on exam, it is noted that the patient has decreased requirement for the drug from TID to 1-2 tabs prn, predominantly during pain exacerbations; it is also noted that Flexeril has been helpful in avoiding continued use of opioids. Therefore, the request for Flexeril may be considered medically necessary, with a plan to wean highly recommended with respect to any future request.

Ambien 10mg, #30 with 3 refills: Upheld

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

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

Decision rationale: Ambien is indicated for short-term treatment of insomnia. Per the ODG Guidelines for Insomnia, Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). If continued treatment with Ambien is required, more detailed documentation of failed sleep treatments and reasoning as to why other pharmacotherapy is not attempted should be provided, along with sleep study data. Without further details regarding the treatment plan and reasoning as to why more appropriate long-term treatment modalities are considered ineffective with respect to sleep, the request is not medically necessary at this time.