

<b>Case Number:</b>	CM14-0159295		
<b>Date Assigned:</b>	10/02/2014	<b>Date of Injury:</b>	03/06/2011
<b>Decision Date:</b>	10/29/2014	<b>UR Denial Date:</b>	09/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2014

### 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 Pain Management 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 57 year old female with a date of injury on 3/6/2011. She is diagnosed with (a) craniocervical headaches; (b) cervical spine sprain/strain, rule out C6-C7 and C7-C8 left radiculopathy; (c) left shoulder sprain/strain with internal derangement and impingement syndrome; (d) lumbar spine sprain/strain with left more than right sciatica, rule out left S1 more than L5 radiculopathy; (e) insomnia secondary to chronic pain, hypertension aggravated secondary to anti-inflammatory medication per the treating physician, internal qualified medical evaluation dated February 25, 2014; and (f) gastritis due to medications, improved. She was seen for an evaluation on August 12, 2014. She had complaints of moderate to severe temporal and occipital headaches. She reported neck pain with radiation to the left shoulder and left upper extremity and low back pain with radiation to both legs. She also stated that she sleeps about four to five hours a night and feels tired and gloomy during the day. An examination of the cervical spine revealed tenderness over the left cervical spine and left upper trapezius muscle as well as mild tenderness about the left paravertebral muscles. Cervical compression test was positive on the left side. Range of motion is limited. There was decreased sensation in the medial left arm, radial left forearm, and median more than ulnar nerve territory of the left hand. Motor power was decreased to manual testing in the left deltoids and biceps at -5/5. An examination of the bilateral shoulders revealed tenderness over the acromioclavicular joint, biceps tendon groove, supraspinatus deltoid complex and rotator cuff on the right and left. Glenohumeral labral testing for instability is negative. Impingement test was positive on the left. Bilateral ranges of motion were limited. An examination of the wrists revealed diffused pain on palpation of the left wrist structures. There was evidence of carpal tunnel syndrome or tendinitis of the left thumb. Phalen's test, Tinel's sign, and Finkelstein's test were positive on the left. There was tenderness over the left thumb carpometacarpal, metacarpophalangeal and proximal interphalangeal joints. An

examination of the lumbar spine revealed tenderness over the left more than the right lumbar paravertebral muscles spinous processes and over the left more than right sacroiliac joints. There was left sciatic notch pain. Gait was antalgic on the left. Range of motion was restricted. There was decreased sensation at the lateral more than medial left thigh, lateral more than medial left leg, and lateral more than dorsomedial left foot. Straight leg raising test was positive on the right. Supine Lasegue's test was bilaterally positive, left more than the right. There was tenderness over the left trochanters and pain to rolling of the left hip. Fabere and reverse Fabere test were positive on the left. An examination of the knees revealed medial joint line tenderness bilaterally. There was moderate Baker's cyst bilaterally. Patellar grinding was 2+ bilaterally.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Ambien 10mg QTY: 150.00:** 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); Zolpidem (Ambien)

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

**Decision rationale:** The request for Ambien 10 mg #150 is not considered medically necessary at this time. From the medical records received for review, it was determined that the injured worker has been taking Ambien since 2011. The use of Ambien beyond two to six weeks is not in accordance with the guidelines. The Official Disability Guidelines (ODG) Treatment in Workers' Comp 2013 stated that the use of zolpidem is approved only for short-term use, usually two to six weeks. Hence, Ambien 10 mg #150 is not medically necessary.

**Norco 10mg QTY: 450.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain; Page(s): 91.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines NSAIDs, specific drug list & adverse effects, Page(s): page(s) 70-72.

**Decision rationale:** Guidelines stated that this medication is recommended for osteoarthritis and off-label for ankylosing spondylitis. The injured worker is not diagnosed with any of these conditions. There was no documentation of the injured worker's subjective and objective response to ibuprofen in 800 mg as guidelines made mention that doses greater than 400 mg have not provided greater relief of pain. The request for ibuprofen 800 mg #300 is not medically necessary.

**Ibuprofen 800mg QTY: 300.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (nonsteroidal anti-inflammatory drugs).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain, Interferential current stimulation (ICS)

**Decision rationale:** The Official Disability Guideline (ODG) Treatment in Workers' Comp 2013 posted criteria for the use of interferential unit though not recommended as an isolated intervention and this has not been met. There was no indication in the medical records reviewed that medications ineffectively controlled her pain to necessitate the need of interferential unit. Hence, proceeding with the use of interferential unit is not in accordance with the guidelines and considered unnecessary at this time. The request for an interferential unit is not medically necessary.

**Interferential (IF) Unit QTY: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential (IF) Unit Page(s): 118-120.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Pain, Interferential current stimulation (ICS)

**Decision rationale:** The Official Disability Guideline (ODG) Treatment in Workers' Comp 2013 posted criteria for the use of interferential unit though not recommended as an isolated intervention and this has not been met. There was no indication in the medical records reviewed that medications ineffectively controlled her pain to necessitate the need of interferential unit. Hence, proceeding with the use of interferential unit is not in accordance with the guidelines and considered unnecessary at this time. The request for an interferential unit is not medically necessary.

**Initial Functional Capacity Evaluation (FCE) QTY: 1.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation CA MTUS/ACOEM Guidelines, 2nd edition, 2004 pages 137-138; regarding Functional Capacity Evaluations (FCE)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7 Independent Medical Examinations and Consultations, page(s) 139 Official Disability Guidelines (ODG) Fitness for Duty Chapter, Functional capacity evaluation (FCE)

**Decision rationale:** Guidelines indicated that there is a question of reliability in solely using functional capacity evaluation (FCE) to identify an injured worker's performance as this may be influenced by other factors that may not be medically related. More so, criteria for functional capacity evaluation have not been met. There was no mention that the injured worker has had

prior unsuccessful attempts to return to work. Hence, the request for a functional capacity evaluation is not medically necessary at this time. The request for a functional capacity evaluation is not medically necessary.