

Case Number:	CM15-0038172		
Date Assigned:	03/06/2015	Date of Injury:	07/17/2002
Decision Date:	06/08/2015	UR Denial Date:	01/30/2015
Priority:	Standard	Application Received:	02/27/2015

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: Pediatrics, Internal 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 54 year old female, who sustained a work injury as a clerk typist on 7/17/02 due to cumulative trauma. She has reported symptoms of bilateral knee pain, back and shoulder pain, and headaches. Prior medical history includes fibromyalgia. The diagnoses have included cervical spine radiculopathy, bilateral knee arthropathy, and lumbar degenerative disc disease. Treatments to date included mediation and pain management evaluation. Medications included Tramadol, Xanax, Ambien, and Cyclo/gaba 10% cream. The treating physician's report (PR-2) from 12/16/14 indicated the injured worker continued to have pain in the upper/lower back and neck region, both wrists, shoulders, and radiating pain in the lower extremities. A cane was used for ambulation and wrist braces were worn. There was decreased range of motion in both shoulders. There was muscle pain and spasms in all four extremities and also in the spine. Examination noted palpable muscle spasms throughout the spine involving the neck an upper/lower back. Range of motion in the neck was greatly decreased with forward flexion to no more than 30-35 degrees and extension was greatly reduced. There was tenderness in both shoulders with some impingement sign on the right. Right range of motion to shoulder was decreased, compared to the left. There were back spasms, with posterior extension and forward flexion to about 45 degrees with numbness and tingling involving the first two toes bilaterally at the bottom of her feet. On 1/30/15, Utilization Review non-certified a Lumbar epidural steroid injection by Interlaminar approach at L5-S1 ; Urine drug screen; Cyclo/gaba 10% cream apply 2-3 times per day for pain , citing the California Medical Treatment Utilization Schedule (MTUS), ACOEM Guidelines. On 1/30/15, Utilization Review non-certified a One (1) year ████████ pool

membership; Xanax 0.25 2-3 times per day as needed #75; Ambien 10 mg every night #30 , citing the Non- California Medical treatment Utilization Schedule (MTUS), ACOEM Guidelines: Official Disability Guidelines (ODG) low back chapter, stress and mental illness chapter of the Integrated treatment/disability guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) year ██████ pool membership: 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.

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 Chapter Gym memberships.

Decision rationale: Per ODG guidelines gym memberships are not recommended as a medical prescription unless a documented home exercise program with periodic assessment and revision has not been effective and there is a need for equipment. Plus, treatment needs to be monitored and administered by medical professionals. Gym memberships, health clubs, swimming pools, athletic clubs, etc., would not generally be considered medical treatment, and are therefore not covered under these guidelines. The request is not medically necessary and appropriate.

Lumbar epidural steroid injection by Interlaminar approach at L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI criteria for Epidural steroid injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: Per MTUS guidelines recommended epidural steroid injections (ESI) as an option for treatment of radicular pain. Criteria for ESI are that the radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing and initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). There is no documentation of a radiculopathy on clinical exam nor on EMG/NCV. This request is not medically necessary and reasonable.

Urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Official Disability Guidelines (ODG) pain chapter, urine drug testing (UDT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; 4) On-Going Management Page(s): 78.

Decision rationale: According to MTUS guidelines, IW's treated with opioids may be required to sign a pain treatment agreement. Part of the agreement may include urine screening for medication and illicit substances. No pain management agreement was submitted stating urinalysis was required and there was no notation of irregular behavior suggesting abuse. This request is not medically necessary and appropriate.

Xanax 0.25 2-3 times per day as needed #75: 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) stress and mental illness chapter of the Integrated treatment/disability guidelines.

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

Decision rationale: According to MTUS guidelines benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. According to the progress notes the IW has been using benzodiazepines for a prolonged time. This request is not medically necessary and appropriate.

Ambien 10 mg every night #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 (ODG) stress and mental illness chapter of the Integrated treatment/disability guidelines.

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: Per ODG pharmacological agents for insomnia should only be used after careful evaluation of potential causes of sleep disturbance for the etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. There is no discussion of an investigation into the origin of the sleep disturbance and non-pharmacological interventions that may have been utilized. Due to adverse effects, FDA now requires lower doses for zolpidem. The dose of zolpidem for women should be lowered from 10 mg to 5 mg for IR products. This request is not medically necessary and appropriate.

Cyclo/gaba 10% cream apply 2-3 times per day for pain: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Cyclobenzaprine and gabapentin are not FDA approved for topical use. This request is not medically necessary and appropriate.