

Case Number:	CM13-0058178		
Date Assigned:	12/30/2013	Date of Injury:	04/28/2010
Decision Date:	04/04/2014	UR Denial Date:	11/14/2013
Priority:	Standard	Application Received:	11/26/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in Illinois. 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 physician 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 patient is a 62-year-old female who reported an injury on 04/28/2010, due to cumulative trauma while performing normal job duties. The patient developed chronic headaches and back pain. The patient developed chronic pain that was managed with medications. The patient's most recent clinical notes documented that the patient had continued pain and headaches. Physical findings included bilateral shoulder pain with limited range of motion and tenderness to palpation along the paravertebral spinal musculature of the lumbar spine, with a positive right-sided straight leg raising test, with decreased sensation in the S1 dermatome. The patient's diagnoses included bilateral shoulder impingement, thoracic and lumbar strain. The patient's treatment plan included continuation of medications and a lumbar MRI.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen Sodium 550mg, 1 tablet twice daily: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anti-inflammatory medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 60, 67.

Decision rationale: The requested Naproxen Sodium 550 mg 1 tablet twice daily is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does support the use of nonsteroidal anti-inflammatory drugs in the management of a patient's chronic pain. However, California Medical Treatment Utilization Schedule also recommends that medication used in the management of chronic pain be supported by documentation of functional benefit and pain relief. The clinical documentation submitted for review does not provide any evidence that the patient has any functional benefit or pain relief resulting from this patient's medication schedule. Therefore, continued use would not be indicated. As such, the requested Naproxen Sodium 550 mg 1 tablet twice daily is not medically necessary or appropriate.

Hydrocodone BIT/Acetaminophen 120 x 2.5-325mg, take one tablet every 8 hours: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-94.

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

Decision rationale: The requested Hydrocodone/Acetaminophen 120 x2.5/325 mg 1 tablet every 8 hours is not medically necessary or appropriate. California Medical Treatment Utilization Schedule res the ongoing use of opioids be supported by documentation of functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence that the patient has any functional benefit from the patient's medication schedule. Additionally, there is not a quantitative assessment provided to establish the efficacy of the requested medication. Also, the documentation did not include any evidence that the patient is monitored for aberrant behavior. Therefore, continued use of this medication would not be supported. As such, the requested Hydrocodone BIT/Acetaminophen 120 x 2.5/325 mg 1 tablet every 8 hours is not medically necessary or appropriate.

Orphenadrine citrate 100mg, #60, take one tablet twice daily: 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.

Decision rationale: The requested Orphenadrine citrate 100 mg #60, take 1 tablet twice daily is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend the long-term use of muscle relaxants in the management of a patient's chronic pain. Additionally, there is no documentation of functional benefit or significant pain relief to warrant extending treatment beyond guideline recommendations. There is no documentation that this is an acute exacerbation of chronic pain. Therefore, the continued use of this medication is not supported. As such, the requested Orphenadrine citrate 100 mg #60, take 1 tablet twice daily is not medically necessary or appropriate.

