

Case Number:	CM14-0002692		
Date Assigned:	01/29/2014	Date of Injury:	01/30/2012
Decision Date:	06/16/2014	UR Denial Date:	12/27/2013
Priority:	Standard	Application Received:	01/07/2014

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 Orthopedic Surgery and is licensed to practice in Texas. 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 43 year old female who sustained an injury on 01/30/12. There did not appear to be any specific mechanism of injury, however, the symptoms were attributed to cumulative trauma at work. Multiple diagnoses included left shoulder impingement syndrome, lumbar (L5-S1) discogenic pain, overuse tendinitis in the left upper extremity, possible right knee internal derangement, and a left ganglion cyst. The last time the patient was seen was in October of 2013 however, the complete report was not available for review. The last complete report for the patient was dated 08/23/13 where complaints of left wrist pain and left shoulder pain were present. On physical examination, there was tenderness to palpation in the left shoulder at the acromioclavicular joint with pain on with some loss of range of motion on flexion/extension. There was also tenderness to palpation over the left wrist at the median nerve with a slight loss of flexion/extension. It was recommended that the injured continue with Cyclobenzaprine, Norco and Omeprazole. A urinalysis sample was obtained at this visit. Alprazolam was also continued at this visit.

IMR ISSUES, DECISIONS AND RATIONALES

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

LORAZEPAM 2MG ONE PO QHS #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: In regards to the requested Lorazepam 2mg quantity 30, the most recent clinical records for this patient did not indicate that this was an active medication. The utilized Alprazolam 2mg. Without an indication that the patient was actively utilizing Lorazepam, or any clinical documentation attributing functional benefits to this medication, this medication is not recommended as medically necessary.

FLEXERIL 10MG PO Q12H PRN #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Page(s): 63-67.

Decision rationale: In regards to the use of Flexeril 10mg quantity 60, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The chronic use of muscle relaxers is not recommended by current evidence based guidelines. At most, muscle relaxers are recommended for short term use only. The efficacy of chronic muscle relaxer use is not established in the clinical literature. There is no indication from the clinical reports that there was any recent exacerbation of chronic pain or any evidence of a recent acute injury. Therefore, this medication is not recommended as medically necessary.

HYDROCODONE/APAP 10/325MG ONE PO Q6-8H #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use Page(s): 88-89.

Decision rationale: In regards to the ongoing use of Hydrocodone 10/325mg quantity 60, the clinical documentation submitted for review did not establish clear functional benefits obtained with this medication. Reduction in pain scores was unclear. There was no clinical documentation regarding any recent toxicology results or long term opioid risk assessments for compliance as recommended by guidelines. Given the lack of any clinical specific functional improvement or pain reduction with the ongoing use of Hydrocodone, and lack of clinical documentation regarding compliance measures, this medication is not recommended as medically necessary.

PRILOSEC 20MG #60 ONE BID PRN: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Proton Pump Inhibitors.

Decision rationale: In regards to the use of Prilosec 20mg quantity 60, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations under Official Disability Guidelines (ODG). There was no indication in the clinical records that there was any substantial gastrointestinal (GI) side effects with the patient's medication regimen as well as objective evidence to support a diagnosis of gastrointestinal reflux disease (GERD) that would have supported the use of proton pump inhibitors, as outlined by current evidence based guidelines. As such, this medication is not recommended as medically necessary.