

Case Number:	CM14-0011072		
Date Assigned:	02/21/2014	Date of Injury:	11/30/2011
Decision Date:	07/16/2014	UR Denial Date:	01/16/2014
Priority:	Standard	Application Received:	01/28/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 48 year old female who was reportedly injured on 11/30/2011. The mechanism of injury was not listed in these records. The most recent progress note, dated 11/15/2013, indicated that there were ongoing complaints of right shoulder pain (9/10), burning, sharp, constant and worse with use of the right arm. The physical exam for this note states the female was in no acute distress, pleasant but concerned. The note was handwritten and very illegible. Previous diagnostic studies included an electromyogram/nerve conduction velocity of the bilateral upper extremities on 12/20/2013 that revealed a normal study. The 11/15/2013 note also referenced an MRI of the right shoulder having rotator cuff tears X 2, as well as joint effusion. The magnetic resonance imaging report was not listed in available medical records. Previous treatment was largely unknown based on the records presented for review. A request had been made for the following medications to include: tramadol 50 mg #60, Flexeril 7.5 mg #60, omeprazole 20 mg #60 and a pain relieving cream containing Flurbiprofen 20%, tramadol 20%, Gabapentin 10%, Amitriptyline 10% and Dextromethorphan 10% and was not certified in the pre-authorization process on 1/16/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRAMADOL 50 MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78, 93-94, 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82,113.

Decision rationale: The MTUS Chronic Pain Guidelines' criteria have not been met as there is no documentation of a maintained increase in function or decrease in pain with the use of this medication. Based on the submitted medical records, the treatment request for Tramadol 50 mg #60 is not medically necessary.

FLEXERIL 7.5 MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41,64.

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

Decision rationale: Given the claimant's date of injury and the lack of objective medical documentation showing a maintained increase in function or decrease in pain with the use of this medication, the guidelines do not support this request for this medication. As such, the request is not medically necessary.

OMEPRAZOLE 20 MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: After reviewing the medical documentation provided, there is no evidence this claimant is at a significantly increased risk for GI upset/bleed. There are no objectified complaints, findings on physical examination or other indicators for this medication. The request is not indicated as medically necessary at this time.

CREAMS FLURBIPROFEN 20%, TRAMADOL 20%, GABAPENTIN 10 %, AMITRIPTYLINE 10%, DEXAMETHORPHAN 10%: Upheld

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

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

Decision rationale: Topical analgesics are considered to be largely experimental in clinical use due to the limited number of randomized controlled trials to determine the efficacy or safety. It is

primarily recommended for neuropathic pain when trials of antidepressants/anticonvulsants have failed. Based on the submitted medical records, the treatment request for this topical analgesic is not medically necessary.