

Case Number:	CM14-0012815		
Date Assigned:	02/24/2014	Date of Injury:	09/06/2006
Decision Date:	08/07/2014	UR Denial Date:	01/28/2014
Priority:	Standard	Application Received:	01/31/2014

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 Anesthesiology, Pain Medicine and is licensed to practice in Florida. 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 77-year-old female who reported an injury on 09/06/2006. The mechanism of injury was not provided within the medical records. The clinical note dated 01/16/2014 indicated a diagnosis of shoulder pain. The injured worker reported increased pain to the right shoulder. The injured worker reported her quality of sleep was poor and her quality of life remained the same. The injured worker reported her activity level had decreased. The injured worker reported she was taking her medication as prescribed and that the medication was working well. On physical examination, the injured worker's neck was restricted with pain. There was tenderness in the paracervical muscles and trapezius. The examination of the shoulder revealed restricted movement with flexion of 85 degrees limited by pain, extension of 55 degrees, and abduction of 85 degrees limited by pain. The injured worker's Hawkins test was positive, Neer's test was positive, and the empty can test was positive. On palpation, there was tenderness in the subdeltoid bursa and trapezius with muscle spasms and tension. The injured worker's Tinel's sign was positive. The injured worker's motor examination was limited by pain. The motor strength of finger flexor was 3 on the right, grip was 3 on the right, and shoulder abduction was 2 on the right. The injured worker's sensory examination was patchy in distribution. The injured worker's prior treatments included medication management. The injured worker's medication regimen included Norco and Relafen. The provider submitted a request for Norco and Relafen. A Request for Authorization was not submitted for review, to include the date the treatment was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

RELAFEN 500MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (NON STEROIDAL ANTI INFLAMMATORY DRUGS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, page 73 Page(s): 73.

Decision rationale: The request for Relafen 500mg #60 is not medically necessary. The California Chronic Pain Medical Treatment Guidelines state Relafen is an NSAID recommended for osteoarthritis, including knee and hip. Relafen should be recommended at at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. The injured worker reported right shoulder pain that had increased since her last visit and reported her activity level has decreased. There is a lack of documentation of a quantified pain assessment and functional improvement with the use of this medication. In addition, improvement is not indicated with the use of this medication. Furthermore, the request does not indicate a frequency for this medication. Therefore, the request for Relafen is not medically necessary.

NORCO 10/325 MG # 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, On-going Management, page 78 Page(s): 78.

Decision rationale: The request for Norco 10/325 mg #90 is not medically necessary. The California MTUS Guidelines recommend the use of opioids for the ongoing management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. The injured worker reports increased right shoulder pain and a decrease in activity level. The efficacy with the medication has not improved. In addition, There was a lack of quantified pain relief and functional improvement with the use of this medication. Moreover, the request did not indicate a frequency for this medication. Therefore, the request is not medically necessary.