

Case Number:	CM14-0016088		
Date Assigned:	06/04/2014	Date of Injury:	04/28/2010
Decision Date:	08/07/2014	UR Denial Date:	02/04/2014
Priority:	Standard	Application Received:	02/07/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in California and Washington. 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 63-year-old female who reported an injury 04/28/2010. The mechanism of injury was not provided within the medical records. The clinical note dated 01/14/2014 is handwritten and largely illegible. The clinical note indicated diagnoses of recurrent subacromial impingement syndrome status post previous left shoulder surgery, degenerative joint disease severe left acromioclavicular joint, superior labrum degenerative type 1 SLAP tear and partial thickness bursal surface rotator cuff tear. The injured worker reported left shoulder pain rated 7/10. The injured worker reported she was scheduled for surgery to the left shoulder. On physical examination of the left shoulder range of motion revealed flexion of 90 degrees, extension of 40 degrees, abduction of 85 degrees, adduction of 35 degrees, internal rotation and external rotation of 60 degrees. The lumbar spine examination revealed straight leg raise positive and decreased range of motion. The injured worker's prior treatments included diagnostic imaging, surgery, and medication management. The injured worker's medication regimen included Imitrex, Naproxen, Norflex, and Hydrocodone/acetaminophen. The provider submitted request for Norflex and Imitrex. A Request for Authorization dated 01/14/2014 was submitted for medications. However, rationale was not provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norflex 100 mg, #60, one tablet twice daily: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (For Pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxant Page(s): 63.

Decision rationale: The request for Norflex 100 mg, #60, one tablet twice daily is not medically necessary. The California Chronic Pain Medical Treatment Guidelines state Norflex is muscle relaxant recommended for short term use for acute exacerbations in patients with chronic low back pain. This medication has been reported in case studies to be abused for euphoria and to have mood elevating effects. There was lack of documentation of efficacy and functional improvement with the use of this medication. In addition, there was lack of evidence of acute exacerbations or flare ups. Moreover, the injured worker has been prescribed this medication since at least 01/14/2014; this exceeds the guidelines recommendation for short term use. Therefore, the request for Norflex is not medically necessary.

Imitrex 50 mg, #9, one at onset of headache, may repeat in two hours, not more than four a day: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Drugs Website.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Head, Triptans.

Decision rationale: The request for Imitrex 50 mg, #9, one at onset of headache, may repeat in two hours, not more than four a day is not medically necessary. The Official Disability Guidelines (ODG) state Imitrex is recommended for migraine sufferers. At marketed doses, all oral triptans (e.g., sumatriptan, brand name Imitrex) are effective and well tolerated. Differences among them are in general relatively small, but clinically relevant for individual patients. A poor response to one triptan does not predict a poor response to other agents in that class. The documentation submitted did not indicate the injured worker had findings that would support she was at risk for migraines. In addition, there was lack of documentation of efficacy and functional improvement with the use of this medication. Moreover, the provider did not indicate a rationale for the request. Therefore, the request for Imitrex is not medically necessary.