

<b>Case Number:</b>	CM14-0111808		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	12/09/2011
<b>Decision Date:</b>	09/22/2014	<b>UR Denial Date:</b>	06/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/17/2014

### 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 Texas and Oklahoma. 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 54-year-old female who reported an injury on 12/09/2011 due to repetitive trauma while performing normal job duties. The injured worker reportedly sustained an injury to her left shoulder. The injured worker was treated with medications, massage, and activity modifications, however, ultimately underwent left shoulder arthroscopic surgery. This was followed by postoperative physical therapy and medications. The injured worker was evaluated on 07/01/2014. It was documented that the injured worker had continued left arm restricted range of motion. Physical findings included paravertebral musculature tenderness to palpation with spasming and limited range of motion of the cervical spine. Evaluation of the left shoulder documented improved range of motion, however with continued limitations. Evaluation of the lumbar spine documented paravertebral musculature tenderness to palpation and spasming with a positive bilateral straight leg raising test. The injured worker's diagnoses are cervical sprain, lumbar sprain/strain, and rotator cuff sprain/strain. The injured worker's medications included Omeprazole, Orphenadrine, Hydrocodone, and Medrox pain relief ointment. The injured worker's treatment plan included continuation of medications. A Request for Authorization for medication refills was dated 07/01/2014. A request for an independent medical review of a denial for medications was submitted on 07/07/2014. The injured worker was again evaluated on 07/29/2014. It was noted that the injured worker had continued left shoulder and neck pain. It was documented that the injured worker's muscle relaxers had not been approved. A refill was provided to help with functional restoration. It was noted that the injured worker's pain medications allowed her to participate in activities of daily living. An additional request for medication refill was submitted. A Request for Authorization form was submitted on 07/29/2014.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Orphenadrine ER 100 mg #60 with two refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

**Decision rationale:** The requested Orphenadrine ER 100 mg #60 with two refills is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not support the use of muscle relaxants in the management of chronic pain. California Medical Treatment Utilization Schedule recommends muscle relaxants be used for short durations of treatment not to exceed to 2 to 3 weeks for acute exacerbations of chronic pain. The clinical documentation submitted for review does indicate that the injured worker has been on this medication for an extended duration of time. Therefore, continued treatment with this medication would not be supported. Furthermore, the request includes 2 refills. This does not allow for timely re-evaluation and assessment to support continued use. The request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Orphenadrine ER 100 mg #60 with two refills is not medically necessary or appropriate.

**Hydrocodone/APAP 10/325 mg #120 with two refills:** Upheld

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

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

**Decision rationale:** The requested Hydrocodone/APAP 10/325 mg #120 with two refills is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic be supported by documented functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the injured worker can participate in activities of daily living resulting from medication usage. However, a quantitative assessment of pain reduction is not provided. Additionally, there is no indication that the injured worker is monitored for aberrant behavior. Furthermore, the request as it is submitted includes 2 refills. This does not allow for timely re-evaluation and assessment of efficacy to support continued use. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Hydrocodone/APAP 10/325 mg #120 with two refills is not medically necessary or appropriate.

**Medrox pain relief ointment (quantity not indicated) with two refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112-113.

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

**Decision rationale:** The requested Medrox pain relief ointment (quantity not indicated) with two refills is not medically necessary or appropriate. The requested medication is a compounded ointment that contains menthol, Methyl Salicylate, Capsaicin, and Lidocaine. California Medical Treatment Utilization Schedule does recommend the use of Menthol and Methyl Salicylate in the management of osteoarthritic pain. California Medical Treatment Utilization Schedule does not support the use of Capsaicin unless all lower levels of chronic pain management have been exhausted. The clinical documentation does not provide any evidence that the injured worker has failed to respond to oral anticonvulsants or antidepressants. Additionally, California Medical Treatment Utilization Schedule does not support the use of Lidocaine in a cream or gel formulation as it is not FDA approved to treat neuropathic pain. Furthermore, the request as it is submitted does not provide a quantity, dosage, or applicable body part. In the absence of this information, the appropriateness of the request itself cannot be determined. Additionally, the request includes 2 refills. This does not allow for timely re-assessment and evaluation to establish efficacy and support continued treatment. As such, the requested Medrox pain relief ointment (quantity not indicated) with two refills is not medically necessary or appropriate.