

Case Number:	CM14-0124782		
Date Assigned:	08/08/2014	Date of Injury:	11/23/2013
Decision Date:	09/16/2014	UR Denial Date:	07/09/2014
Priority:	Standard	Application Received:	08/06/2014

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 records, presented for review, indicate that this 49-year-old individual was reportedly injured on 11/23/2013. The mechanism of injury was noted as repetitive motion. The most recent progress note, dated 07/07/2014, indicated that there were ongoing complaints of left shoulder and right wrist pains. The physical examination demonstrated left shoulder positive tenderness to palpation over the greater tuberosity and coracoid process. There were also limited range of motion, positive Neer's sign, positive thumb down sign, and positive arc of rotation. Muscle strength was 5/5. Right wrist had no evidence of thenar or hypo thenar muscle wasting, and positive tenderness to palpation over the right wrist specifically over the scaphoid bone, snuffbox, and transverse carpal ligament. Crepitation was with wrist flexion and extension. There was decreased grip strength. Decreased sensation was over the thumb, index, and middle fingers. Recent diagnostic studies included an MRI of the left shoulder, left elbow, and right wrist. Previous treatment included medications, bracing, and conservative treatment. A request had been made for cyclobenzaprine 5 mg #30, tramadol ER 150 mg #30 and hydrocodone/APAP 2.5/325 mg #30 and was not certified in the pre-authorization process on 07/09/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 5 mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 41, 64.

Decision rationale: The MTUS guidelines support the use of skeletal muscle relaxants like Flexeril for the short-term treatment of pain; but advise against long-term use. Given the claimant's date of injury and clinical presentation, the guidelines do not support this request for chronic pain. As such, the request is not medically necessary.

Tramadol ER 150 mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 60, 78, 83.

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

Decision rationale: The MTUS treatment guidelines support the use of Tramadol (Ultram) for short-term use, after there has been evidence of failure of a first-line option, evidence of moderate to severe pain, and documentation of improvement in function with the medication. Given the clinical presentation and lack of documentation of functional improvement with Tramadol, the request is not considered medically necessary.

Hydrocodone/APAP 25/325 mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 60, 78, 83.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78, 88, 91.

Decision rationale: Norco (hydrocodone/acetaminophen) is a short acting opiate indicated for the management of moderate to severe breakthrough pain. The MTUS guidelines support short-acting opiates at the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The injured employee has chronic pain; however, there is no objective clinical documentation of improvement in the pain or function with the current regimen. As such, this request for Norco is not medically necessary.