

Case Number:	CM14-0125552		
Date Assigned:	08/11/2014	Date of Injury:	06/22/2013
Decision Date:	09/22/2014	UR Denial Date:	07/14/2014
Priority:	Standard	Application Received:	08/08/2014

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 & Rehabilitation, Pain Medicine 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 41 year old male with a reported date of injury on 05/22/2013. The diagnoses were left shoulder pain, neck pain, fibromyositis, and chronic pain syndrome. The past treatments were pain medication, physical therapy and acupuncture. There was no surgical history documented in the records. On 07/02/2014, the subjective complaints were pain to the left shoulder and left wrist that radiates to the back of the head, rated 7/10. The physical examination noted joint swelling of the left wrist and left shoulder. The medications included Voltaren gel, Cyclobenzaprine, Naproxen, Ibuprofen and Tramadol. The treatment plan was to continue medications. The rationale was to decrease pain. The request for authorization form is dated 07/07/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 10mg #30 x1 Refill: Upheld

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

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

Decision rationale: The California MTUS guidelines indicate Cyclobenzaprine is recommended for a short course of therapy not to exceed 3 weeks. The injured worker has chronic left upper extremity pain. The records indicate that she has been on Cyclobenzaprine since 03/11/2014 which is longer than 3 weeks. Additionally there is no medication frequency submitted with the request. Since the patient has been on Cyclobenzaprine longer than 3 weeks and there is no medication frequency with the request, Cyclobenzaprine 10mg #30 is not medically necessary.

Tramadol 50mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-78.

Decision rationale: The California MTUS guidelines state that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. It is noted on 07/02/2014 that the patient is on naproxen and has 20% pain relief from the medication. Additionally there is no medication frequency submitted with the request. Since there is no documented evidence of a failed trial of non-opioid analgesics and the clinical note indicates that use of Naproxen was effective in decreasing pain, Tramadol 50mg #120 is not medically necessary.

Voltaren 1% Topical Gel 100gm tube x1 Refill: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

Decision rationale: The California MTUS guidelines Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment and has not been evaluated for treatment of the spine, hip or shoulder. The injured worker has chronic left shoulder pain. The application of Voltaren to the shoulder is not supported in the guidelines. Additionally there is no medication frequency submitted with the request. As such, Voltaren 1% Topical Gel 100gm tube x1 Refill is not medically necessary.