

Case Number:	CM14-0139620		
Date Assigned:	09/05/2014	Date of Injury:	06/20/1993
Decision Date:	11/12/2014	UR Denial Date:	08/16/2014
Priority:	Standard	Application Received:	08/28/2014

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 Family Medicine and is licensed to practice in Texas & Mississippi. 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 58-year-old who reported on 06/20/1993 due to an unknown mechanism of injury. The injured worker reportedly sustained an injury to her cervical spine. The injured worker's treatment history included medications, physical therapy, and a TENS unit. The injured worker was evaluated on 07/28/2014. It was documented that the injured worker's medications included methocarbamol 750 mg and hydrocodone/acetaminophen 7.5/325 mg. It was noted that the injured worker was able to maintain activities of daily living with medication usage. The injured worker was monitored with CURES reporting and urine drug screens. Physical findings included diminished range of motion of the cervical spine, a positive compression sign bilaterally, and tenderness to the right paracervical musculature, middle to superior trapezius, middle trapezius and rhomboid trigger areas. The injured worker's diagnoses included disorder of the shoulder joint, spinal enthesopathy of the cervical spine, mood disorders, and anxiety disorder. The injured worker's treatment plan included a continued home exercise program and a refill of medications. No Request for Authorization Form was submitted to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methocarbamol 750mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The California Medical Treatment Utilization Schedule does not recommend the use of muscle relaxants for chronic pain. The clinical documentation submitted for review does indicate that the injured worker has been taking this medication since at least 02/2014. The California Medical Treatment Utilization Schedule does not recommend the use of muscle relaxants beyond 2 to 3 weeks for acute exacerbations of chronic pain. The clinical documentation submitted for review indicates that the injured worker has been on this medication for duration to extend treatment guidelines. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. As such, the requested Methocarbamol 750 mg #30 is not medically necessary or appropriate. 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. Therefore the request is not medically necessary.

Hydrocodone - Acetaminophen 7.5/325mg #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the use of medications allows for maintenance of activities of daily living. It is also noted that the patient is monitored for aberrant behavior with CURES reporting and urine drug screens. However, a quantitative assessment of pain relief to support ongoing use was not provided. 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/acetaminophen 7.5/325 mg #90 is not medically necessary..