MAXIMUS Federal Services

Case Number:	CM14-0150606		
Date Assigned:	09/18/2014	Date of Injury:	07/06/2011
Decision Date:	10/23/2014	UR Denial Date:	09/02/2014
Priority:	Standard	Application Received:	09/08/2014

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, has a subspecialty in 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 39-year-old male who reported an injury on 07/06/2011 due to an unknown mechanism. Diagnoses were thoracic sprain/strain, myofascial strain of lumbar spine, mild right carpal tunnel syndrome, psychiatric diagnosis, cervical spine disc bulge at C4-5 of 1 mm, and occipital neuralgia. Physical examination on 08/12/2014 revealed complaints of constant pain in his suboccipital head that traveled to the top of the head and behind both ears. The pain was rated 8/10. There were complaints of frequent right shoulder pain. The pain was rated 4/10. There were complaints of right wrist pain, the pain was rated 7/10. There were also complaints of numbness and tingling. There were complaints of constant neck pain which was described as sharp and stabbing. The pain was rated 8/10. There were other complaints that aggravated the pain which included neck bending, repetitive overhead reaching, repetitive lifting, and repetitive carrying. Examination of the wrist revealed Phalen's test, Tinel's sign, and Finkelstein's tests were positive on the right wrist. It was reported that the injured worker would be starting postoperative rehabilitation physical therapy. Medications were Soma, Norco, TG Ice compounded cream. Treatment plan was to take medications as directed. The rationale and request for authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management; Hydrocodone/Acetaminophen Page(s): 78; 91.

Decision rationale: The decision for hydrocodone is not medically necessary. The California Medical Treatment Utilization Schedule states hydrocodone/acetaminophen is indicated for moderate to moderately severe pain and there should be documentation of the 4 A's for ongoing monitoring including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behavior. The 4 A's for ongoing monitoring of an opioid medication were not reported. The efficacy of this medication was not reported. The request does not indicate a frequency or a quantity for the medication. Therefore, this request is not medically necessary.

Tramadol: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol; Ongoing Management Page(s): 82,93,94,113; 78.

Decision rationale: The decision for tramadol is not medically necessary. The California Medical Treatment Utilization Schedule states central analgesic drugs such as tramadol (Ultram) are reported to be effective in managing neuropathic pain and it is not recommended as a first line oral analgesic. The medical guidelines recommend that there should be documentation of the 4 A's for ongoing monitoring including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behavior. The 4 A's for ongoing monitoring were not reported. The efficacy of this medication was not reported. The request does not indicate a frequency or a quantity for the medication. Therefore, this request is not medically necessary.

Flurbiprofen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67.

Decision rationale: The decision for flurbiprofen is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that NSAIDs are recommended for short term symptomatic relief of low back pain. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual patient treatment goals. There should be documentation of objective functional improvement and objective decrease in pain. The request does not indicate a frequency or a quantity for the medication. There was no documentation of objective functional improvement

or objective decrease in pain. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, this request is not medically necessary.