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| Case Number: | CM14-0155623 | | |
| Date Assigned: | 09/25/2014 | Date of Injury: | 10/27/2010 |
| Decision Date: | 12/03/2014 | UR Denial Date: | 09/09/2014 |
| Priority: | Standard | Application Received: | 09/23/2014 |

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 Anesthesiology, and is licensed to practice in Tennessee, North Carolina, and Georgia. 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 43-year-old male who reported an injury on 10/27/2010. While working as a technician, he was assaulted by an agitated patient for approximately half hour with pulling, twisting, and turning primarily to the left arm and also the right arm. The injured worker complained of left upper extremity pain. The diagnoses included neuralgia, possible minor complex regional pain syndrome, shoulder strain, left wrist ligament, and soft tissue damage to the left forearm and right hand/wrist. The diagnostics included an MRI of the left shoulder dated 07/27/2012 which revealed an insertional fraying and reactive marrow changes at the supraspinatus entheses, narrowing of the anterior portion of the subacromial outlet, down sloping position of the acromion and a small undersurface spur secondary impingement, and glenohumeral capsulitis with inflammatory changes off the AC joint. The bone scan dated 07/27/2012 revealed mild abnormalities at the PIP and MCP joints of the right middle finger and PIP joint of the index finger along with the MCP joint of the right thumb. The MRI of the left hand dated 07/27/2012 revealed chronic wear in the TFC complex and the scapholunate ligament with ECU tendinosis and developing thin split. There was a narrow, small radial volar ganglion and small capsular synovitis of the wrist. The nerve conduction velocity study dated 10/27/2012 revealed abnormal for suprascapular nerve compromise at or near the suprascapular notch on the left with demyelination and mild median nerve compromise in the forearm segment. The MRI of the right hand and wrist dated 03/2014 revealed normal findings. Prior surgeries included a left wrist arthroscopy and debridement and a left shoulder arthroscopy with debridement. Past treatments included injections, massage, non-steroidal anti-inflammatories, ice, rest, heat, sauna, and whirlpool paraffin. The physical examination dated 07/25/2014 demonstrated a full range of motion of the shoulders, elbows, wrists, and digits with some upper paracervical discomfort primarily at the levator scapula and upper trapezium. There was anterior shoulder discomfort

noted directly overlying the long head of the biceps and tenderness to the abductor and greater trochanter portion of the left hip. No antalgic gait was noted. The treatment plan included Vicoprofen, Robaxin, and Pennsaid. The Request for Authorization dated 09/25/2014 was submitted with documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone with Ibuprofen #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Pain Management, Hydrocodone/Ibuprofen Page(s): 78, 98.

Decision rationale: The request for Hydrocodone with Ibuprofen #120 is not medically necessary. The California MTUS Guidelines recommend short acting opioids such as Norco for controlling chronic pain. For ongoing management, there should be documentation of the 4 A's, including analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. The documentation provided was not evident of measurable functions. The documentation did not address the ongoing pain management. The activities of daily living were not addressed. Adverse side effects were not addressed. The clinical notes also indicate that the injured worker has returned to work. Additionally, the guidelines state that Ibuprofen is recommended for short term use only, generally less than 10 days. The request is for #120 tablets, exceeding the recommended short term use. As such, the request is not medically necessary.

Robaxin 750mg #75: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics Page(s): 64.

Decision rationale: The request for Robaxin 750 mg #75 is not medically necessary. The California MTUS Guidelines recommend as an option for short term symptomatic relief for lower back pain. It is used with caution as a second line option for the short term treatment of acute exacerbations. The documentation indicates that the injured was prescribed Robaxin on 04/22/2014 and again is noted to be prescribed Robaxin on 07/25/2014. Additionally, the request is for an additional 75 tablets, exceeding the guidelines recommendation for short term. The guidelines do not support Robaxin as a chronic medication. As such, the request is not medically necessary.

Pennsaid: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAID's.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The request for Pennsaid is not medically necessary. The California MTUS indicates the non-steroidal anti-inflammatory agents that the efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2 week period. When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. In this study the effect appeared to diminish over time and it was stated that further research was required to determine if results were similar for all preparations. Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). The clinical notes dated 07/26/2014 stated that the injured worker reported his right knee pain an 8/10, but also indicated that his "medication was working well." The clinical notes also indicated that the injured worker reported that the TENS unit was relieving his pain. The guidelines do not recommend topical non-anti-inflammatory medications as they are inconsistent in treatment. The request did not address the frequency, duration and dosage. As such, the request is not medically necessary.