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| Case Number: | CM14-0165074 | | |
| Date Assigned: | 10/10/2014 | Date of Injury: | 04/08/2013 |
| Decision Date: | 11/10/2014 | UR Denial Date: | 09/16/2014 |
| Priority: | Standard | Application Received: | 10/07/2014 |

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, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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 25-year-old male who reported an injury on 04/08/2013. The mechanism of injury was not submitted for clinical review. The diagnoses included cervicalgia, right shoulder internal derangement, and rotator cuff tear. The previous treatments included medication and surgery. Within the clinical note dated 07/22/2014, it was reported the injured worker complained of right shoulder pain. He rated his pain at 9/10 in severity. The injured worker complained of neck pain. He rated his neck pain 8/10 in severity. Upon physical examination, the provider noted the injured worker had shoulder range of motion; however, there was pain with extension of the cervical spine. Sensory intact to pinprick in all dermatomes. The provider requested flurbiprofen/cyclobenzaprine; however, a rationale was not submitted for clinical review. The Request for Authorization was not submitted for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective: Compound Flurbiprofen/Cyclobenzaprine provided on date of service 7/29/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41, 72, 111-112.

Decision rationale: The request for retrospective compound flurbiprofen/cyclobenzaprine provided on date of service 07/29/2014 is not medically necessary. The California MTUS Guidelines note topical NSAIDs are recommended for osteoarthritis and tendinitis, in particular that of the knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. Flurbiprofen is recommend for osteoarthritis and mild to moderate pain. Cyclobenzaprine is recommended for a short course of therapy. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request as submitted failed to provide the frequency of the medication. The request as submitted failed to provide the dosage and quantify of the medication. Additionally, a treatment site was not provided for clinical review. Therefore, the request is not medically necessary.