

<b>Case Number:</b>	CM14-0031518		
<b>Date Assigned:</b>	04/09/2014	<b>Date of Injury:</b>	05/10/2010
<b>Decision Date:</b>	05/28/2014	<b>UR Denial Date:</b>	01/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/04/2014

### 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 and is licensed to practice in Texas. 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 51-year-old male who reported an injury on 05/10/2010. The mechanism of injury was not provided. The injured worker underwent a right shoulder rotator cuff repair with arch decompression and partial distal clavicle excision and a release of the right middle trigger finger on 09/17/2013. Medication history included opiates and muscle relaxants as of 09/2013. The documentation of 01/15/2014 revealed the patient had complaints of constant sharp pain in the cervical spine with radiation of pain and stiffness and the injured worker indicated medications only helped to control pain temporarily. There were also complaints of sharp pain in the lumbar spine with radiation of pain and stiffness. There were spasms upon palpation of the cervical spine and lumbar spine. The diagnoses included cervical spine musculoligamentous injury, lumbar spine musculoligamentous injury, right hand 3rd finger status post surgery, and right shoulder status post surgery. The treatment plan included Norco 10/325 mg, Flexeril 5 mg, flurbi cream, Gabacyclotram, and physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**NORCO 10/325MG #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60,78.

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the injured worker had been on the medication for greater than 2 months. There was a lack of documentation of the above criteria. The request as submitted failed to indicate the frequency for the requested medication. The request for NORCO 10/325 MG #60 is not medically necessary and appropriate.

**FLEXERIL 5MG #90:** Upheld

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

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

**Decision rationale:** California MTUS Guidelines recommend muscle relaxants as a second line option for the short-term treatment of acute low back pain. Their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication for greater than 2 months. There was a lack of documentation of objective functional improvement. The request as submitted failed to indicate the frequency for the requested medication. The request for Flexeril 5 mg #90 is not medically necessary and appropriate.