

<b>Case Number:</b>	CM14-0031958		
<b>Date Assigned:</b>	04/09/2014	<b>Date of Injury:</b>	08/01/2012
<b>Decision Date:</b>	05/28/2014	<b>UR Denial Date:</b>	01/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2014

### 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 Occupational Medicine and is licensed to practice in California. 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 applicant is a represented [REDACTED] employee who has filed a claim for chronic shoulder, hip, neck, and elbow pain reportedly associated with an industrial injury of August 1, 2012. In a Utilization Review Report of January 9, 2014, the claims administrator denied requests for a seated walker, CT scan of the hip, Flexeril, and Lortab. Thus far, the applicant has been treated with the following: Analgesic medications; work restrictions; a hip corticosteroid injection; unspecified amounts of physical therapy over the life of the claim; attorney representation; and transfer of care to and from various providers in various specialties. In a March 11, 2014 progress note, the applicant reported persistent pain about the hip, exacerbated by pressure. Unrestricted hip range of motion was noted. The attending provider reviewed the results of CT scanning of the hip dated January 27, 2014 which was negative for any significant hip pathology. A walker was endorsed to avoid purported falls associated with hip pain. Flexeril and Lortab were also endorsed. The applicant was asked to obtain a trochanteric bursal hip injection. The applicant was given work restrictions, which the applicant's employer was apparently unable to accommodate. An earlier note of January 14, 2014 was also notable for comments that the applicant had persistent hip pain with an unsteady gait reported at that point in time. The applicant's gait was not assessed on this visit or on prior visits. The applicant was afraid of falling; it was stated on several occasions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**SEATED WALKER:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Walking Aids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices Topic Page(s): 99.

**Decision rationale:** The MTUS/ACOEM Guidelines suggests that every attempt should be made to maintain the applicant at maximum levels of activity. It is further noted that, in the MTUS Chronic Pain Medical Treatment Guidelines that functional mobility deficits can be resolved through usage of a cane or walker. In this case, however, the attending provider has not detailed, elaborated upon or expounded upon the nature of the employee's functional mobility deficits. The employee gait has not been described or detailed on any recent progress note. While the attending provider stated that the employee was concerned about falls, there is no mention that the claimant is actually falling and no description of the gait on any recent office visit. Therefore, the request for a seated walker is not medically necessary and appropriate.

**FLEXIRIL 7.5MG, #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Topic Page(s): 41.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines, regarding Cyclobenzaprine or Flexeril to other agents is not recommended. In this case, the applicant is using at least one another analgesic medication, Lortab. Adding cyclobenzaprine or Flexeril to the mix is not recommended. Therefore, the request for Flexeril 7.5 mg #90 is not medically necessary and appropriate.

**LORTAB 7.5/500MG, #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines When to Continue Opioids Topic Page(s): 80.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines, the cardinal criteria for continuation of opioid therapy include evidence of successful return to work, improved functioning, and/or reduced pain achieved as a result of ongoing opioid therapy. In this case, however, these criteria have not been met. The employee does not appear to be working with rather proscriptive limitations in place. There is no mention of reduction in pain scores or improvement in function achieved as a result of ongoing Lortab usage. Therefore, the request for Lortab 7.5/500 mg # 60 is not medically necessary and appropriate.

