

Case Number:	CM14-0033076		
Date Assigned:	03/19/2014	Date of Injury:	01/10/2011
Decision Date:	04/25/2014	UR Denial Date:	02/14/2014
Priority:	Standard	Application Received:	03/14/2014

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 patient is a 63-year-old who reported an injury on January 10, 2011. The mechanism of injury was not stated. The patient is currently diagnosed with left shoulder pain, status post arthroscopy and closed manipulation, right shoulder strain, cervical strain, possible stress syndrome, possible cardiovascular problems, and insomnia. The patient was seen by [REDACTED] on January 13, 2014. The patient reported persistent neck and right shoulder pain. Physical examination revealed tenderness over the paraspinous musculature of the cervical spine, muscle spasm, limited range of motion, tenderness over the anterior capsule and acromioclavicular joint, positive Neer and Hawkin's testing, positive impingement and O'brien's testing, decreased shoulder range of motion on the right and crepitus. Treatment recommendations at that time included continuation of current medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE TRAMADOL ER 150 MG, 60 COUNT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient has continued to report persistent pain. Satisfactory response to treatment was not indicated by a decrease in pain level, increase in function, or improved quality of life. The retrospective request for Tramadol ER 150 mg, 60 count, is not medically necessary or appropriate.

TRAMADOL ER 150 MG, 60 COUNT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient has continued to report persistent pain. Satisfactory response to treatment was not indicated by a decrease in pain level, increase in function, or improved quality of life. The request for Tramadol ER 150 mg, 60 count, is not medically necessary or appropriate.

RETROSPECTIVE HYDROCODONE/APAP 10/325 MG, 60 COUNT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient has continued to report persistent pain. Satisfactory response to treatment was not indicated by a decrease in pain level, increase in function, or improved quality of life. The retrospective request for Hydrocodone/APAP 10/325 mg, 60 count, is not medically necessary or appropriate.

HYDROCODONE/APAP 10/325 MG, 60 COUNT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient has continued to report persistent pain. Satisfactory response to treatment was not indicated by a decrease in pain level, increase in function, or improved quality of life. The request for Hydrocodone/APAP 10/325 mg, 60 count, is not medically necessary or appropriate.

CYCLOPENZAPRINE 7.5 MG, 60 COUNT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state muscle relaxants are recommended as nonsedating second line options for short-term treatment of acute exacerbations. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. As per the documentation submitted, the patient does demonstrate palpable muscle spasm. However, the current request for cyclobenzaprine quantity #60 exceeds guideline recommendations. The request for Cyclobenzaprine 7.5 mg, 60count, is not medically necessary or appropriate.

RETROSPECTIVE NAPROXEN 550 MG, 100 COUNT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state NSAIDS (non-steroidal anti-inflammatory drugs) are recommend for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDS are recommended as a second line treatment after acetaminophen. There is no evidence of long-term effectiveness for pain or function. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continued to report persistent pain. The retrospective request for Naproxen 550 mg, 100count, is not medically necessary or appropriate.

NAPROXEN 550 MG, 100 COUNT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state NSAIDS are recommend for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDS are recommended as a second line treatment after acetaminophen. There is no evidence of long-term effectiveness for pain or function. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continued to report persistent pain. There was no documentation of satisfactory response to treatment. The request for Naproxen 550 mg, 100 count, is not medically necessary or appropriate.