

Case Number:	CM14-0053248		
Date Assigned:	07/07/2014	Date of Injury:	01/10/2010
Decision Date:	08/28/2014	UR Denial Date:	04/01/2014
Priority:	Standard	Application Received:	04/21/2014

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:

Patient is a 54-year-old male who has submitted a claim for status post left shoulder surgery repair, left biceps tendon rupture, right forearm flexor tendon rupture, chronic pain syndrome, right ulnar neuropathy, and right carpal tunnel syndrome associated with an industrial injury date of 01/10/2010. Medical records from 2013 to 2014 were reviewed. The Patient complained of bilateral upper extremity numbness and tingling sensation, graded 7-10/10 in severity. The Patient also reported right hip pain with muscle spasm, aggravated by prolonged sitting. He reported that medications relieved the pain by 25% and allowed him to perform household chores and to walk 20 minutes longer. Physical examination showed a palpable left biceps tendon rupture and left forearm flexor tendon mass. Tenderness was noted at the left shoulder joint, right medial epicondyle, and lateral aspect of the right hip. Range of motion of the left shoulder was restricted. Tinel's sign was positive over the right cubital tunnel. Right hip internal and external rotation was painful. CURES report from 10/21/2013 was consistent with the prescribed medications. Treatment to date has included left shoulder surgery repair, acupuncture, physical therapy, home exercise program, and medications such as Percocet, ketoprofen, Norco, and cyclobenzaprine. Utilization review from 03/20/2014 denied the requests for Norco 10/325mg #30, Ketoprofen 75mg trial as Advil was tried over the weekend without any benefit, Cyclobenzaprine 7.5mg tablet #90, and Percocet 10/325mg #90. The reasons for denial were not made available.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #30: Overturned

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

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

Decision rationale: As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, the patient has been on opioids since 2008. He reported that medications relieved the pain by 25%, allowed him to perform household chores and to walk 20 minutes longer. CURES report of 10/21/2013 was consistent with the prescribed medications. Guideline criteria for continuing opioid management have been met. Therefore, the request for Norco 10/325mg #30 is medically necessary.

Ketoprofen 75mg trial as Advil was tried over the weekend without any benefit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 46.

Decision rationale: As stated on page 46 of the California MTUS Chronic Pain Medical Treatment guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and that there is no evidence of long-term effectiveness for pain or function. In this case, the patient was prescribed ketoprofen as adjuvant therapy to opioids. However, there was no discussion concerning rationale for NSAID when present opioids provided him pain relief and functional improvement. There was no acute worsening of symptoms to warrant adjuvant NSAID therapy. The medical necessity cannot be established due to insufficient information. Therefore, the request for Ketoprofen 75mg trial as Advil was tried over the weekend without any benefit. Therefore, this request is not medically necessary.

Cyclobenzaprine 7.5mg tablet #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

Decision rationale: According to page 41-42 of the CA MTUS Chronic Pain Medical Treatment Guidelines, sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. Based on the records submitted, the patient has been on cyclobenzaprine since January 2014. He reported pain relief and functional improvement from its use. Although the most recent report cited that the patient complained of muscle spasm, the long-term use of cyclobenzaprine was not recommended. There is no discussion concerning need for variance from the guidelines. Therefore, the request for Cyclobenzaprine 7.5mg tablet #90 is not medically necessary.

Percocet 10/325mg #90: Overturned

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

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

Decision rationale: As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, the patient has been on opioids since 2008. He reported that medications relieved the pain by 25%, allowing him to perform household chores and to walk 20 minutes longer. CURES report from 10/21/2013 was consistent with the prescribed medications. Guideline criteria for continuing opioid management has been met. Therefore, the request for Percocet 10/325mg #90 is medically necessary.