

Case Number:	CM14-0056829		
Date Assigned:	07/09/2014	Date of Injury:	04/08/2008
Decision Date:	08/11/2014	UR Denial Date:	04/04/2014
Priority:	Standard	Application Received:	04/25/2014

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 & Rehabilitation 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 injured worker is a 51-year-old female who reported an injury on 04/18/2008. The mechanism of injury was not provided within the medical records. The clinical note dated 04/26/2014 indicated diagnoses of hand joint pain, tenosynovitis of the hand, disorder of bursa of shoulder region, shoulder joint pain, right upper extremity carpal tunnel syndrome, chronic right shoulder myofascial pain and chronic pain syndrome. The injured worker reported continued right upper extremity pain and numbness, especially with repetitive activities. The injured worker reported she continued working. The injured worker reported opiates had improved her function. Upon physical examination, the injured worker reported muscle aches, weakness, joint pain, and swelling in the extremities. The injured worker had hypesthesia in the right upper extremity in the median nerve distribution. The injured worker had myofascial tenderness over the entire upper extremity, including both the medial and lateral epicondyle. The injured worker's prior treatments included diagnostic imaging, surgery, home exercise, and medication management. The injured worker's medication regimen included Celebrex, cyclobenzaprine, Neurontin, OxyContin, and Percocet. The provider submitted a request for OxyContin, Percocet, and cyclobenzaprine. A Request for Authorization was not submitted for review to include the date the treatment was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin 15mg, Qty: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Therapeutic Trial of Opioids & Opioids for Chronic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, On-going Management Page(s): 78.

Decision rationale: The California MTUS Guidelines recommend the use of opioids for the on-going management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is a lack of significant evidence of an objective assessment of the injured worker's pain level, functional status, and evaluation of risk for aberrant drug use behaviors and side effects. In addition, the request did not indicate a frequency for this medication. Therefore, the request for Oxycontin 15mg Qty: 60 is not medically necessary and appropriate.

Percocet 5/325mg, Qty: 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Therapeutic Trial of Opioids & Opioids for Chronic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, On-going Management Page(s): 78.

Decision rationale: The California MTUS Guidelines recommend the use of opioids for the on-going management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is a lack of significant evidence of an objective assessment of the injured worker's pain level, functional status, and evaluation of risk for aberrant drug use behaviors and side effects. In addition, the request did not indicate a frequency for this medication. Therefore, the request for Percocet 5/325mg Qty: 90 is not medically necessary and appropriate.

Cyclobenzaprine 10mg, Qty: 60: 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 (Flexeril) Page(s): 41-42.

Decision rationale: The CA MTUS guidelines recommend cyclobenzaprine (Flexeril) as an option, using a short course of therapy. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system (CNS) depressant for acute exacerbations and/or muscle spasms of the low back. The documentation submitted did not indicate the injured worker had any findings that would support she was at risk for acute exacerbations or any muscle spasms. In addition, the documentation submitted did not indicate how long the injured worker had been utilizing cyclobenzaprine. Moreover, there was a lack of documentation of the efficacy and functional improvement with the use of this medication. Moreover, there was lack of a pain assessment for

the injured worker. Furthermore, the request did not indicate a frequency for this medication. Therefore, the request for Cyclobenzaprine 10mg Qty: 60 is not medically necessary and appropriate.