

Case Number:	CM14-0079118		
Date Assigned:	07/18/2014	Date of Injury:	02/05/2010
Decision Date:	09/18/2014	UR Denial Date:	05/15/2014
Priority:	Standard	Application Received:	05/29/2014

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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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 54-year-old female who reported an injury on 02/05/2010. The mechanism of injury involved a fall. Current diagnoses include neck pain, right medial and lateral epicondylitis, bilateral shoulder impingement, right thumb CMC joint arthritis, and right finger PIP joint inflammation of the right hand. The injured worker was evaluated on 06/27/2014. It is noted that the injured worker has been previously treated with medication management, bracing, hot/cold therapy, and TENS therapy. The current medication regimen includes Tylenol No. 3, Flexeril, Voltaren gel 1%, and Norco. The injured worker presented with complaints of persistent pain rated 8/10 with spasm in the neck, right shoulder, right hand, and lower back. The injured worker is currently working full time. Physical examination on that date revealed no acute distress, 15 degrees cervical extension 25 degrees cervical flexion, 120 degrees right upper extremity abduction, 140 degrees left upper extremity abduction, and limited range of motion due to pain and stiffness. It is noted that a right and left shoulder MRI obtained on 06/15/2012 indicated small fluid collection in the AC joint. Treatment recommendations included continuation of the current medication regimen and a request for 6 sessions of acupuncture treatment. There was no request for authorization form submitted on the requesting date.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO 10/325MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES/OPIOIDS Page(s): 75,76-77.

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

Decision rationale: California MTUS 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. The injured worker has continuously utilized Norco 10/325 mg since 12/2013. There is no documentation of objective functional improvement. There is also no frequency listed in the request. As such, the request for Norco 10/325 mg #30 is not medically necessary and appropriate.

VOLTAREN GEL 1% 100G X3 BOTTLES: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC MEDICAL TREATMENT GUIDELINES/TOPICAL ANALGESICS Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: California MTUS Guidelines state the only FDA approved topical NSAID is diclofenac 1% gel, which is indicated for the relief of osteoarthritis pain in the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. Therefore, the current request cannot be determined as medically appropriate in this case. Additionally, the patient has continuously utilized Voltaren gel 1% since 12/2013 without any evidence of objective functional improvement. There is also no frequency listed in the request. As such, the request for Voltaren gel 1% 100g, three bottles are not medically necessary and appropriate.

FLEXERIL 5MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES/ MUSCLE RELAXANTS Page(s): 63-64.

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

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as non-sedating second-line options for short-term treatment of acute exacerbations. There is no documentation of palpable muscle spasm or spasticity upon physical examination. California MTUS Guidelines state Flexeril should not be used for longer than 2 to 3 weeks. The patient has

continuously utilized this medication since 12/2013. There is also no frequency listed in the request. As such, the request for Flexeril 5mg #60 is not medically necessary and appropriate.