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| Case Number: | CM14-0181265 | | |
| Date Assigned: | 11/05/2014 | Date of Injury: | 05/22/2012 |
| Decision Date: | 01/28/2015 | UR Denial Date: | 09/25/2014 |
| Priority: | Standard | Application Received: | 10/30/2014 |

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 Anesthesiology, has a subspecialty in Pain Medicine, and is licensed to practice in Florida and 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 45 year old male who was injured on 5/22/2012. The diagnoses are bilateral carpal tunnel syndrome, right wrist and right shoulder pain. There are associated diagnoses of insomnia, depression, The 2014 MRI of the right shoulder showed supraspinatus tendinosis and mild acromioclavicular degenerative changes. The 2014 MRI of the left shoulder showed prior rotator cuff surgery and degenerative changes of the bony glenoid. The past surgery history is significant for left shoulder arthroscopy surgical repair. On 6/10/2014, [REDACTED] noted subjective complaints of bilateral shoulders and wrist pain. There was positive impingement test and tenderness of the subacromial tenderness. On 8/17/2014, [REDACTED] noted objective findings of bilateral positive Tinel, Phalen and compression tests of the median nerves. There was associated numbness with thenar muscle atrophy. An MRI of the right shoulder was denied by carrier for non covered body part. A Utilization Review determination was rendered on 9/25/2014 recommending non certification for MRI scapula, TGHOT 180gm #1, Fluriflex 180gm #1 and modified certification for cyclobenzaprine 7.5mg #90 to #45, Nebumetone 750mg #90 to #45.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nabumetone 750 mg, ninety count: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 72 - 73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 67-73. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

Decision rationale: The CA MTUS and the ODG guidelines recommend that NSAIDs can be utilized for the treatment of exacerbations of chronic musculoskeletal pain. The chronic use of NSAIDs can be associated with the development of cardiac, gastrointestinal and renal complications. The records did not indicate any NSAID related adverse effect. The medication is efficacious. The criteria for the use of Nebumetone 750mg #90 was met.

MRI of scapula: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Shoulder.

Decision rationale: The CA MTUS and the ODG guidelines recommend that MRI can be utilized for the evaluation of musculoskeletal pain when clinical and plain radiology test are inconclusive and for the presence of neurological / vascular deficits or 'red flag' conditions. The records indicate that the patient had MRI of the shoulders in 2014. There is no indication of subjective and objective findings indicative of worsening shoulder function or scapula abnormality. The criteria for MRI scapula was not met.

Cyclobenzaprine 7.5 mg, ninety count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41 and 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 63-66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

Decision rationale: The CA MTUS and the ODG guidelines recommend that muscle relaxants can be utilized for periods of less than 4 weeks for the treatment of exacerbation of musculoskeletal pain that did not respond to standard treatment with NSAIDs and PT. The chronic use of muscle relaxants is associated with the development of dependency, tolerance, sedation, addiction and adverse interaction with opioids and other sedatives. The records indicate that the patient had utilized cyclobenzaprine longer than the guideline recommended duration. The patient is also utilizing other medications. There is no documentation of intractable muscle spasm. The criteria for the use of cyclobenzaprine 7.5mg #90 was not met.

TGHot 180 grams: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2
Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)
Pain Chapter.

Decision rationale: The CA MTUS and the ODG guidelines recommend that topical product can be utilized for the treatment of localized neuropathic pain if treatments with first line oral anticonvulsant and antidepressant medications have failed. The records did not show that the patient failed orally administered first line medications. The TGHoT contains tramadol 8%/gabapentin 10%/ menthol 2%/ camphor 2%/ capsaicin 0.05%. The guidelines recommend that topical products be tried and evaluated individually for efficacy. There is lack of guideline or FDA support for the use of topical formulations of tramadol and gabapentin. The use of menthol and camphor for the treatment of chronic musculoskeletal pain was not recommended by the guidelines. The criteria for the use of TGHoT 180gm was not met.

Fluriflex 180 grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 111 - 114.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2
Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)
Pain Chapter.

Decision rationale: The CA MTUS and the ODG guidelines recommend that topical product can be utilized for the treatment of localized neuropathic pain if treatments with first line oral anticonvulsant and antidepressant medications have failed. The records did not show that the patient failed orally administered first line medications. The Fluriflex contains flurbiprofen 15% and cyclobenzaprine 10%. The guidelines recommend that topical products be tried and evaluated individually for efficacy. There is lack of guideline or FDA support for the use of topical formulations of cyclobenzaprine. The patient is also utilizing oral doses of cyclobenzaprine and nebumetone for the treatment of chronic musculoskeletal pain. The use of multiple NSAIDs is associated with increased risk of NSAIDs related complications. The criteria for the use of Fluriflex 180gm was not met.