

Case Number:	CM14-0201758		
Date Assigned:	12/12/2014	Date of Injury:	05/28/2002
Decision Date:	01/28/2015	UR Denial Date:	11/03/2014
Priority:	Standard	Application Received:	12/02/2014

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 Emergency 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 with reported date of injury on 11/17/2010. Mechanism of injury is due to repetitive trauma. Patient has a diagnosis of R lateral epicondylitis, R deQuervain's disease, R ulnar nerve cubital tunnel/Guyon's canal neuritis, R thumb stenosing tenosynovitis and R carpal tunnel syndrome. Patient is post R carpal tunnel release 2/29/12 and multiple cortisone injections. Medical reports reviewed. Last report available until 11/11/2014. Patient complains of pain to R wrist, swelling in R wrist with R thumb soreness. Physical therapy has improved range of motion. Objective exam reveals improved range of motion to L wrist in ulnar deviation. Decreased tenderness in R 1st dorsal compartment. Mild edema. Positive Finkelstein's. Urine Drug Screen dated 8/22/14 was appropriate but was negative for hydrocodone. Current medications documented as Omeprazole, Norco and Fexmid. Independent Medical Review is for Hydrocodone/acetaminophen 10/325mg #180, Cyclobenzaprine 7.5mg #180, Cyclobenzaprine/Gabapentin 10/10% cream #1 and Urine Drug Screen. Prior Utilization Review on 11/3/14 recommended non-certification.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/ Acetaminophen 10/325mg Qty: 180.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76.

Decision rationale: Norco is acetaminophen with hydrocodone, an opioid. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. There is no documentation of objective improvement with this medication and no appropriate documentation of monitoring. Prior UDS dated 8/22/14 was negative for hydrocodone with no note mentioning inconsistency. Prescription for Hydrocodone/acetaminophen is not medically necessary.

Cyclobenzaprine 7.5mg Qty: 180.00: 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 Cyclobenzaprine Page(s): 41-42.

Decision rationale: Flexeril is cyclobenzaprine, a muscle relaxant. As per MTUS guidelines, evidence show that it is better than placebo but is considered a second line treatment due to high risk of adverse events. It is recommended only for short course of treatment for acute exacerbations. There is some evidence of benefit in patients with fibromyalgia. Patient has been on this medication chronically. There is no documentation of improvement. There is no documentation of any complaints of muscle spasms. The number of tablets is excessive and medically inappropriate. The request is not medically necessary.

Transdermal Cream Cyclobenzaprine 10% and Gabapentin 10% Qty: 1.00: 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 Topical Analgesics Page(s): 111-113.

Decision rationale: As per MTUS guidelines "Any compound product that contains a drug or drug class that is not recommended is not recommended." 1) Cyclobenzaprine: is an oral muscle relaxant. It is not FDA approved for topical application. MTUS guidelines do not recommend topical use. It is not medically recommended or appropriate. 2) Gabapentin: Gabapentin is an anti-epileptic. As per MTUS guidelines, it is not recommended with no evidence to support its use as a topical product. It is not recommended. This request is not medically necessary.

Urine Drug Screen Qty: 1.00: Upheld

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

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

Decision rationale: As per MTUS Chronic pain guidelines, drug screening may be appropriate as part of the drug monitoring process. Primary requesting physician for urine drug test does not document monitoring of CURES and asking questions concerning suspicious activity or pain contract. There is no documentation from the provider concerning the patient being a high risk for abuse. Patient had a recent UDS from 8/22/14 that while inconsistent due to lack of hydrocodone, it lacked any illicit drugs. Urine Drug Screen us not medically necessary.