

Case Number:	CM15-0009168		
Date Assigned:	01/27/2015	Date of Injury:	11/30/2000
Decision Date:	05/05/2015	UR Denial Date:	01/14/2015
Priority:	Standard	Application Received:	01/15/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: New York

Certification(s)/Specialty: Pediatrics, Internal Medicine

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 (IW) is a 49 year old male who sustained an industrial injury on 11/30/2000. He has reported bilateral shoulder pain and bilateral elbow pain. The diagnoses have included medial epicondylitis, elbow pain, and extremity pain. Treatment to date has included medications, physical therapy, and a home exercise program. The IW has also received an injection in the right elbow. The IW's pain has been unchanged with exception of an increase in muscle spasms. There is no report in change of location of pain, no new problems, or side effects. Currently, the IW complains of tenderness to palpation in the acromioclavicular joint, glenohumeral joint and subdeltoid bursa. The elbow exam showed no erythema, swelling, bruising, incision or drainage. No limitation in movement was noted. There was no elbow instability. Tenderness to palpation was noted over the lateral epicondyle. The IW is also being evaluated for a psychological work injury. The patient is permanent and stationary. On 01/14/2015 Utilization Review non-certified a request for Norco 10/325mg, quantity: 180, noting the request is a duplicate as confirmed in a peer-to-peer phone call. The MTUS Chronic Pain Guidelines, Opioids were cited. On 01/14/2015 Utilization Review non-certified a request for Norco 10/325mg #180 with one refill to outside Rx noting the request is a duplicate as confirmed in a peer to peer phone call. The MTUS Chronic Pain Guidelines, Opioids were cited. On 01/14/2015 Utilization Review non-certified a request for Norco (brp) 10/325mg, quantity: 120, noting again the request is a duplicate as confirmed in a peer to peer phone call The MTUS Chronic Pain Guidelines, Opioids were cited. On 01/14/2015 Utilization Review non-certified a request for Zanaflex 4mg, quantity: 60 with 1 refill, noting the records provided for the review

did not establish a medical necessity for this medication. The MTUS Chronic Pain Guidelines, Opioids were cited. On 01/15/2015, the injured worker submitted an application for IMR for review of the non-certified items.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg, quantity: 180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use 4) On-Going Management Page(s): 78.

Decision rationale: The IW has been on long term opioids which are not recommended. Additionally, documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Additionally, this is a duplicate request for medication already approved for the IW. This request is not medically necessary and reasonable at this time.

Norco 10/325mg #180 with one refill to outside Rx: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 93.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use 4) On-Going Management Page(s): 78.

Decision rationale: The IW has been on long term opioids which are not recommended. Additionally, documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Additionally, this is a duplicate request for medication already approved for the IW. This request is not medically necessary and reasonable at this time.

Norco (brp) 10/325mg, quantity: 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): (s) 78-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use 4) On-Going Management Page(s): 78.

Decision rationale: The IW has been on long term opioids which are not recommended. Additionally, documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Additionally, this is a duplicate request for medication already approved for the IW. This request is not medically necessary and reasonable at this time.

Zanaflex 4mg, quantity: 60 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): (s) 63, 64, and 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain); Antispasticity/Antispasmodic Drugs Page(s): 66.

Decision rationale: According to guidelines tizanidine is indicated for spasticity and that one study showed significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain. In review of the records provided it was noted that the IW complained of increased spasms however, there was no muscle spasm noted on exam. The request is not medically necessary and appropriate at this time.