

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0218484 | | |
| Date Assigned: | 11/10/2015 | Date of Injury: | 06/15/2000 |
| Decision Date: | 12/24/2015 | UR Denial Date: | 10/27/2015 |
| Priority: | Standard | Application Received: | 11/06/2015 |

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: California
 Certification(s)/Specialty: Emergency 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 is a 54 year old female, who sustained an industrial injury on 6-15-2000. The injured worker is diagnosed with bilateral forearm-wrist tendinitis and right thumb trigger finger, right shoulder strain-impingement, cervical-trapezial musculoligamentous sprain-strain with bilateral upper extremity radiculitis, thoracolumbar musculoligamentous sprain-strain with bilateral lower extremity radiculitis, post right elbow surgery and post bilateral carpal tunnel release. Her work status is temporary total disability. Notes dated 8-28-15 and 10-2-15 reveals the injured worker presented with complaints of frequent moderate to severe right shoulder pain described as dull, aching, throbbing, pounding, weakness and muscle soreness and rated at 6-7 out of 10. The pain is increased with lifting, pushing, pulling and reaching. She reports constant, moderate to severe neck pain described as dull, sharp, cramping, numbness, achy and soreness that radiates numbness and tingling into her bilateral upper extremities. Physical examinations dated 8-28-15 and 10-2-15 revealed right shoulder with crepitus. There is tenderness over the right trapezius muscle, supraspinatus muscle, acromioclavicular joint and subacromial region. The right shoulder range of motion is decreased and painful in all planes, muscle strength is 4 out of 5 in all planes. The Apley's scratch test, impingement sign and cross arm are all positive on the right. The cervical spine examination has not changed. Treatment to date has included medications; Percocet (6-2015), Zanaflex (6-2015) Lidoderm patch and Celebrex, which reduces her pain from 8 out of 10 to 5 out of 10 for 4 hours. She is able to walk and stand for 15 minutes longer, sit for 30 minutes longer and do household chores (cooking, dishes, laundry, self-care and dressing). She experiences improved participation in home exercise program

and improved sleep, per note dated 10-2-15. Diagnostic studies include urine toxicology screen. A request for authorization dated 10-2-15 for Percocet 5 mg #120 is modified to #51 and Zanaflex 2 mg #120 is modified to #67, per Utilization Review letter dated 10-27-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 5 mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain, Opioids, long-term assessment.

Decision rationale: Percocet is acetaminophen and oxycodone, an opioid. Patient has chronically been on an opioid pain medication. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. Documentation fails criteria. While there is claim of improvement in pain and function, this claim has been unchanged for over 6months. There is no documentation of any long-term plan or plan to wean from opioid therapy. There is lack of any actual use of 1st line medication for chronic pain and neuropathic pain from provider. Lack of objective benefit or long-term plan does not support percocet. The request is not medically necessary.

Zanaflex 2 mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: Zanaflex (Tizanidine) is an antispasmodic muscle relaxant. It is FDA approved for muscle spasms. As per MTUS guidelines, muscle relaxants should be used for short-term use and for flare ups only. There is no documentation of muscle spasms and patient has been on this medication chronically and the number of tablets requested is not appropriate. Tizanidine is not medically necessary.