

<b>Case Number:</b>	CM15-0030656		
<b>Date Assigned:</b>	02/24/2015	<b>Date of Injury:</b>	07/03/2013
<b>Decision Date:</b>	04/10/2015	<b>UR Denial Date:</b>	01/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/19/2015

### 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: Physical Medicine & Rehabilitation

### 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 43-year-old male who reported injury on 07/03/2013. The mechanism of injury was repetitive motion. The diagnoses included severe left carpal tunnel syndrome, right shoulder impingement, right lateral epicondylitis of the elbow, and right carpal tunnel syndrome. The injured worker underwent an MRI of the right shoulder on 06/30/2014, and electrodiagnostic studies on 01/07/2015. Prior treatments included physical therapy, home exercise, medication management, and the use of a TENS unit, as well as injections in the right shoulder. Documentation of 01/23/2015 revealed the injured worker's medications maintained the activities of daily living, including grocery shopping, essential household functions, and caring for himself. The injured worker had improved range of motion. The injured worker's medications were noted to include tramadol ER 300 mg daily, and it was noted that the injured worker's achy pain was decreased with NSAIDs by approximately 3 points on a 10-point scale. The physical examination revealed the injured worker had a positive Tinel's and Phalen's, and diminished sensation in the median nerve distribution on the left. There was no Request for Authorization submitted for the requested medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Keflex 550mg #28:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Infectious Disease.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Infectious Disease Chapter, Cephalexin.

**Decision rationale:** The Official Disability Guidelines indicate that Keflex is recommended as a first line treatment for cellulitis and other conditions. There was a lack of documented rationale for the requested medication. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Keflex 550 mg #28 is not medically necessary.

**Anaprox 550mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non steroid anti-inflammatory drugs (NSAIDS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines indicate that NSAIDS are recommended for short term symptomatic relief of low back pain. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual patient treatment goals. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review indicated the injured worker had an objective decrease in pain and objective functional improvement. The duration of use could not be established through supplied documentation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Anaprox 550 mg #60 is not medically necessary.