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| Case Number: | CM15-0057342 | | |
| Date Assigned: | 04/02/2015 | Date of Injury: | 05/16/2012 |
| Decision Date: | 05/04/2015 | UR Denial Date: | 02/26/2015 |
| Priority: | Standard | Application Received: | 03/25/2015 |

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, Pain Management

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 57 year old female, who sustained an industrial injury on May 16, 2012. She reported developing pain in the neck, low back, shoulders, arms, hands, and feet carrying out the heavy work of a machine operator. The injured worker was diagnosed as having cervical radiculopathy, shoulder impingement, wrist sprain/strain, and lumbar radiculopathy. Treatment to date has included physical therapy, electrodiagnostic study, and medication. Currently, the injured worker complains of bilateral hips and right shoulder pain. The Primary Treating Physician's report dated February 16, 2015, noted the physical examination to show spasm and tenderness to palpation in the cervical spine paraspinal muscles, with reduced sensory in the bilateral median nerve distribution. The shoulder examination was noted to show positive bilateral impingement signs. The left wrist first dorsal compartment was tender to palpation, with positive Tinel's tests bilaterally, and positive Finkelstein's test on the left. The lumbar spine was noted to have spasm and tenderness to palpation of the paraspinal muscles, with positive sitting straight leg raise bilaterally. The treatment plan included continuation of medication, physical therapy as authorized, and requests for authorization for Medrox Pain Relief Ointment, Hydrocodone-APAP (Norco), Naproxen Sodium, Omeprazole, Ibuprofen, Orphenadrine, and Capsaicin cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orphenadrine ER 100 MG Take 1 Twice Daily Qty 60 with 2 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, 9792.26 MTUS (Effective July 18, 2009) Page(s): 63-66 of 127.

Decision rationale: Regarding the request for orphenadrine (Norflex), Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the medication. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Finally, there is no documentation of failure of first-line treatment options, as recommended by guidelines. In the absence of such documentation, the currently requested orphenadrine (Norflex) is not medically necessary.

Capsaicin .025 Percent Cream, Apply to Affected Area Twice A Day with 2 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, 9792.26 MTUS (Effective July 18, 2009) Page(s): 111-113 of 127.

Decision rationale: Regarding the request for capsaicin cream, CA MTUS states that capsaicin is, "Recommended only as an option in patients who have not responded or are intolerant to other treatments." Within the documentation available for review, there is no indication that the patient has not responded to or is intolerant to other treatments, and it is noted that she is currently utilizing multiple pain medications. Given all of the above, the requested capsaicin cream is not medically necessary.