

Case Number:	CM14-0118527		
Date Assigned:	08/06/2014	Date of Injury:	05/14/2014
Decision Date:	10/08/2014	UR Denial Date:	07/16/2014
Priority:	Standard	Application Received:	07/29/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Texas. 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:

Medical records reflect the claimant is a 71 year old male who sustained a work injury on 5-14-14. On this date, he was moving a convertible sofa weighing approximately 250 lbs and felt a pop sensation and pain to his neck, left shoulder and left upper arm. The claimant has been treated with medications, physical therapy and an injection to the left shoulder. He has returned to work with restrictions. Office visit on 6-26-14 notes the claimant has a diagnosis of full thickness rotator cuff tear with retraction per MRI, tendinitis/impingement syndrome bilateral shoulders, cervical sprain and strain. On exam, the claimant had decreased range of motion, decreased strength, normal sensory exam, deep tendon reflex (DTR) are equal and symmetrical bilaterally.

IMR ISSUES, DECISIONS AND RATIONALES

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

Analgesic Ultram 50 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 113.

Decision rationale: Chronic Pain Medical Treatment Guidelines reflect that Tramadol (Ultram) is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral

analgesic. There is an absence in documentation noting the claimant has failed first line of treatment or that she requires opioids at this juncture. Therefore, the medical necessity of this request is not established.

Anti-inflammatory Naproxen 550 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS
Page(s): 67-73.

Decision rationale: Chronic Pain Medical Treatment Guidelines as well as ODG reflect that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. There is an absence in documentation documenting medical necessity for the long term use of an NSAID. There is no documentation of functional improvement with this medication. Therefore, the medical necessity of this request is not established.

Muscle Relaxant Soma 350 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Soma
Page(s): 29.

Decision rationale: Chronic Pain Medical Treatment Guidelines notes that Soma is not recommended. This medication is not indicated for long-term use. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active Metabolite is Meprobamate (a schedule-IV controlled substance). There are no extenuating circumstances to support the long term use of