

Case Number:	CM14-0146027		
Date Assigned:	09/12/2014	Date of Injury:	06/25/2013
Decision Date:	10/14/2014	UR Denial Date:	08/21/2014
Priority:	Standard	Application Received:	09/08/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in California. 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:

According to the records made available for review, this is a 55-year-old female with a 6/25/13 date of injury. At the time (7/30/14) of request for authorization for Flexeril 10mg 1 qhs #30, Norco 10/325 mg 1 bid #60, and Voltaren cream #1, there is documentation of subjective (right acromioclavicular joint pain radiating to the biceps tendon and to the pectoral muscles) and objective (decreased right shoulder range of motion with pain and guarding, tenderness of the right trapezius, rhomboids, greater occiput, acromioclavicular joint, anterior glenohumeral joint, and biceps tendon groove, positive impingement sign, positive cross arm test, and 4/5 right rotator cuff strength) findings, current diagnoses (right shoulder rotator cuff tear, right humeral head avascular necrosis, and right shoulder impingement syndrome), and treatment to date (medications (including Relafen, Xanax, and Hydrochlorothiazide), physical therapy, TENS unit, and steroid injections). Medical report identifies that there is ongoing opioid medication agreement. In addition, medical report identifies that there is contraindication to oral NSAIDs. Regarding Flexeril, there is no documentation of short-term (less than two weeks) treatment. Regarding Voltaren cream, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist).

IMR ISSUES, DECISIONS AND RATIONALES

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

FLEXERIL 10MG 1 QHS #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASMODICS Page(s): 63-64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril), Page(s): 41-42. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain)

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that Flexeril is recommended for a short course of therapy. ODG identifies that muscle relaxants are recommended as a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Within the medical information available for review, there is documentation of diagnoses of right shoulder rotator cuff tear, right humeral head avascular necrosis, and right shoulder impingement syndrome. In addition, there is documentation of Flexeril used as a second line agent. However, there is no documentation of acute muscle spasms or acute exacerbation of chronic low back pain. In addition, given a request of Flexeril 10mg 1 qhs #30, there is no (clear) documentation of short-term (less than two weeks) treatment. Therefore, based on guidelines and a review of the evidence, the request for Flexeril 10mg 1 qhs #30 is not medically necessary.

NORCO 10/325 MG 1 BID #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 91, 76-78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Page(s): 74-80.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. Within the medical information available for review, there is documentation of diagnoses of right shoulder rotator cuff tear, right humeral head avascular necrosis, and right shoulder impingement syndrome. In addition, given documentation that there is ongoing opioid medication agreement, there is documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Therefore, based on guidelines and a review of the evidence, the request for Norco 10/325 mg 1 bid #60 is medically necessary.

VOLTAREN CREAM #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory agents (NSAIDs) Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Diclofenac sodium

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and short-term use (4-12 weeks), as criteria necessary to support the medical necessity of Voltaren Gel. ODG identifies documentation of failure of an oral NSAID or contraindications to oral NSAIDs, as criteria necessary to support the medical necessity of Voltaren Gel. Within the medical information available for review, there is documentation of diagnoses of right shoulder rotator cuff tear, right humeral head avascular necrosis, and right shoulder impingement syndrome. In addition, there is documentation that there is contraindication to oral NSAIDs. However, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). Therefore, based on guidelines and a review of the evidence, the request for Voltaren cream #1 is not medically necessary.