

Case Number:	CM14-0088988		
Date Assigned:	10/01/2014	Date of Injury:	04/04/2011
Decision Date:	10/31/2014	UR Denial Date:	05/19/2014
Priority:	Standard	Application Received:	06/13/2014

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 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:

The injured worker is a 50-year-old female with a reported date of injury on 04/04/2011. The injury reportedly occurred when a stack of files on a shelf above the injured worker fell and as a chart brushed her head, she shrugged her shoulder upward, which caused pain to her neck and radiated to her right shoulder. Her diagnoses were noted to include bilateral carpal tunnel syndrome, possible cervical radiculopathy, and right shoulder girdle muscles pathology. Her previous treatments were noted to include acupuncture, chiropractic treatments, and medications. The progress note dated 04/30/2014 revealed complaints of pain to the cervical spine and decreased range of motion to the right shoulder with myospasms and numbness. The physical examination revealed range of motion limited with pain to the right shoulder and pain with taut muscles and spasms. Trigger points were noted to the right shoulder and there was a sensory loss at the right upper extremity and right hand. The Request for Authorization form was not submitted within the medical records. The retrospective request was for 1 prescription of amitriptyline DT, diclofenac F, 60 Tylenol No. 3 (codeine/APAP), 60 Soma (carisoprodol) 350 mg, and 60 ibuprofen 800 mg provided on 05/24/2014; however, the provider's rationale was not submitted within the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for one prescription of Amitriptyline DT provided on 5/24/12:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Ho KY, Huh, BK, White WD, Yeh CC, Miller EJ; Topical amitriptyline versus lidocaine in the treatment of neuropathic pain. Clin J Pain. 2008 Jan; 24(1): 51-5

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13.

Decision rationale: The injured worker complained of neck and right shoulder pain. The California Chronic Pain Medical Treatment Guidelines recommend antidepressants as a first line medication for treatment of neuropathic pain, and they are recommended especially if pain is accompanied by insomnia, anxiety, or depression. There should be documentation of an objective decrease in pain and objective functional improvement to include an assessment in the changes or the use of other analgesic medications, sleep quality and duration, and psychological assessments. There is a lack of documentation regarding efficacy and improved functional status with the utilization of this medication. There is a lack of documentation regarding sleep quality and duration. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.

Retrospective request for one prescription of Diclofenac F provided on 5/24/12: Upheld

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

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

Decision rationale: The injured worker complains of neck and right shoulder pain. The California Chronic Pain Medical Treatment Guidelines indicate that NSAIDs are recommended for short term symptomatic relief for 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. There is a lack of documentation regarding efficacy and improved functional status with utilization of this medication. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.

Retrospective request for 60 Tylenol 3 (codeine APAP) provided on 5/24/12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management, Page(s): 78.

Decision rationale: The injured worker complained of neck and right shoulder pain. According to the California Chronic Pain Medical Treatment Guidelines, the ongoing use of opioid medications may be supported with detailed documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines also state that the 4 A's for ongoing monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors, should be addressed. There is a lack of documentation regarding evidence of decreased pain on a numerical scale with the use of medications. There is a lack of documentation regarding improved functional status with activities of daily living with the use of medications. There is a lack of documentation regarding side effects and the recent urine drug screen performed 04/2014 that was consistent with therapy. Therefore, due to lack of documentation regarding significant pain relief, improved functional status, and side effects, the ongoing use of opioids is not supported by the guidelines. Additionally, the request failed to provide the frequency at which this medication is to be utilized. As such, the request is not medically necessary.

Retrospective request for 60 Soma (Carisoprodol) 350mg provided on 5/24/12: Upheld

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

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

Decision rationale: The injured worker complained of pain to the neck and right shoulder. The California Chronic Pain Medical Treatment Guidelines do not recommend Soma, as the medication is not indicated for long term use. Soma is a commonly prescribed, centrally acting muscle relaxant whose primarily active metabolite is meprobamate. Carisoprodol abuse has been noted in order to augment or alter effects of other drugs. There is a lack of documentation regarding efficacy and improved functional status with the utilization of this medication. There was a lack of documentation regarding the length of time the injured worker has been utilizing this medication. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.

Retrospective request for 60 Ibuprofen 800mg provided on 5/24/14: 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.

Decision rationale: The injured worker complains of neck and right shoulder pain. The California Chronic Pain Medical Treatment Guidelines indicate that NSAIDs are recommended for short term symptomatic relief for 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. There is a lack of documentation regarding efficacy and improved functional status with utilization of this medication. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.