

Case Number:	CM14-0098057		
Date Assigned:	09/16/2014	Date of Injury:	01/17/2009
Decision Date:	10/16/2014	UR Denial Date:	06/12/2014
Priority:	Standard	Application Received:	06/26/2014

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 Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 59-year-old male who reported an injury on 10/10/2007. The mechanism of injury was not submitted for clinical review. The diagnoses included blevel cervical disc protrusion, moderate left median neuropathy of the wrist, carpal tunnel syndrome, and chronic right ulnar neuropathy. The previous treatments included medication and surgery. Within the clinical note dated 05/07/2014, it was reported the injured worker complained of low back pain and left shoulder pain rated 5/10 in severity. He complained of aching in the neck, which he rated 4/10 in severity. On physical examination of the cervical spine, the provider noted tenderness at the occipital insertion of the paracervical musculature, but range of motion was noted to be 30 degrees of flexion and 20 degrees of extension. Upon examination of the lumbar spine, the provider indicated the injured worker had tenderness from the thoracolumbar spine down to the base of the pelvis. The paralumbar musculature was tight bilaterally. The range of motion was noted to be flexion at 20 degrees and extension at 15 degrees. The provider requested hydrocodone, FluriFlex, and TG Hot for pain. The Request for Authorization was submitted and dated 05/17/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone (Norco) 10/325mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management, Page(s): page(s) 78..

Decision rationale: The request for hydrocodone/Norco 10/325 mg #60 is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the use of a urine drug screen was not submitted for clinical review. Therefore, the request is not medically necessary.

FluriFlex Cream 240mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112..

Decision rationale: The request for FluriFlex cream 240 mg is not medically necessary. The California MTUS Guidelines recommend topical NSAIDs for osteoarthritis and tendonitis, in particular, that of the knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the request submitted failed to provide the treatment site of the medication. Therefore, the request is not medically necessary.

Tg Hot 240mg: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112.

Decision rationale: The request for TG Hot 240 mg is not medically necessary. The California MTUS Guidelines recommend topical NSAIDs for osteoarthritis and tendonitis, in particular, that of the knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the request submitted failed to provide the treatment site of the medication. Therefore, the request is not medically necessary.

