

Case Number:	CM15-0011408		
Date Assigned:	01/29/2015	Date of Injury:	09/19/2014
Decision Date:	03/27/2015	UR Denial Date:	01/06/2015
Priority:	Standard	Application Received:	01/21/2015

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, New York, Florida

Certification(s)/Specialty: Internal Medicine, Pulmonary Disease, Critical Care Medicine

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 39-year-old female who reported an injury on 09/19/2014. The mechanism of injury was unspecified. Her diagnoses included cervical and thoracic sprain/strain, right shoulder strain with impingement, left shoulder strain with possible rotator cuff, left elbow strain, left wrist De Quervain's tenosynovitis, lumbosacral strain, and right hip strain. Her past treatments included medications, 6 sessions of physical therapy, and occupational therapy. On 12/10/2014, the injured worker complained of bilateral upper extremity, bilateral shoulder, right hip, and low back pain. On 12/02/2014, the injured worker complained of low back pain, left elbow pain, and left wrist/hand pain. Low back pain was rated 4/10 to 5/10, left elbow was rated 2/10, and left wrist was rated 5/10 to 6/10. The treatment plan included acetaminophen, Flexeril, and Voltaren gel. A rationale was not provided for review. A Request for Authorization form was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Tylenol #3, QTY: 60: Upheld

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

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

Decision rationale: The request for 1 prescription of Tylenol #3, QTY: 60 is not medically necessary. According to the California MTUS Guidelines, there should be ongoing monitoring for patients on opioids to include pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant or drug related behaviors. The injured worker was indicated to have been on Tylenol No. 3 for an unspecified duration of time. However, there is a lack of documentation in regards to objective functional improvement, objective decrease in pain with medication use, or evidence of monitoring for side effects and for aberrant drug related behaviors. In the absence of the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

1 prescription of Cyclobenzaprine 10mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxant Page(s): 63-66.

Decision rationale: The request for 1 prescription of Cyclobenzaprine 10mg #60 is not medically necessary. According to the California MTUS Guidelines, muscle relaxants are indicated as a nonsedating form with caution as a second line option for short term treatment of acute exacerbations in patients with chronic low back pain. Furthermore, the guidelines indicate that efficacy appears to diminish over time and prolonged use leads to dependence. The injured worker was indicated to have been on cyclobenzaprine for an unspecified duration of time. However, there is a lack of documentation to indicate the injured worker had acute exacerbation in chronic low back pain. In addition, the guidelines do not support the use of long term therapy as efficacy appears to diminish over time and may lead to dependence. Based on the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

Unknown prescription of Motrin Cream: Upheld

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

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

Decision rationale: The request for Unknown prescription of Motrin Cream is not medically necessary. According to the California MTUS Guidelines, topical analgesics are primarily recommended after a trial of antidepressants and anticonvulsants has failed. More specifically, topical NSAIDs have been indicated to be inconsistent. However, they are indicated for the

treatment of osteoarthritis for the first 2 weeks as efficacy diminishes beyond then. The injured worker was indicated to have been on a Motrin cream for an unspecified duration of time. However, there was a lack of documentation to indicate the injured worker had failed a trial of antidepressants and anticonvulsants. There is also a lack of documentation to indicate the injured worker had osteoarthritis and tendinitis. In the absence of the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.