

Case Number:	CM15-0123413		
Date Assigned:	07/01/2015	Date of Injury:	01/17/2012
Decision Date:	08/04/2015	UR Denial Date:	06/15/2015
Priority:	Standard	Application Received:	06/26/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 51 year old male, who sustained an industrial injury on 1/17/12. He reported pain in his neck, shoulder and arms related to repetitive motions and lifting. The injured worker was diagnosed as having status post right shoulder arthroscopic surgery, thoracic spondylosis, bilateral upper extremity radiculopathy and cervical spine pain with central disc bulges. Treatment to date has included physical therapy, a cervical MRI, a bilateral shoulder MRI, Norco and an EMG/NCS study. On 3/4/14, the treating physician noted decreased range of motion in the cervical spine, bilateral shoulders and bilateral elbows. The injured worker also had a positive Tinel's sign in both wrists. He rated his pain an 8/10. As of the PR2 dated 6/8/15, the injured worker reports no relief from Lidoderm patch and has heartburn with oral medications. The treating physician noted no changes in functional status since the last examination. The treating physician requested to start Cyclobenzaprine/Tramadol cream #1 x 1 refill.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine/Tramadol apply, two (2) times per day cream #1 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

Decision rationale: Regarding the request for cyclobenzaprine/tramadol, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Muscle relaxants are not supported by the CA MTUS for topical use. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. Given all of the above, the requested cyclobenzaprine/tramadol is not medically necessary.