

Case Number:	CM15-0093950		
Date Assigned:	05/20/2015	Date of Injury:	06/17/2003
Decision Date:	06/26/2015	UR Denial Date:	04/28/2015
Priority:	Standard	Application Received:	05/15/2015

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

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 was a 58 year old female, who sustained an industrial injury, June 7, 2003. The injured worker previously received the following treatments right shoulder MRI, Norco, Cyclobenzaprine, lumbar spine MRI, cervical spine MRI and TENS (transcutaneous electrical nerve stimulator) unit. The injured worker was diagnosed with moderate narrowing at L4-L5 and mild narrowing at L5-S1 anterolisthesis L4-L5 with moderate to severe arthritis of the L4-L5 per lumbar MRI, interstitial tear of the distal superior fibers of the subscapularis tendon, moderate tendinosis infraspinatus and supraspinatus tendons and subacromial bursitis per right shoulder MRI and moderate spinal canal stenosis at C5-C6 and C6-C7 per cervical spine MRI. According to progress note of April 13, 2015 the injured workers chief complaint was 4 out of 10 neck pain, which builds up to a headache. The back pain was rated at 4 out of 10. And left upper extremity pain was 5 out of 10, dull achy and sharp components occasionally radiates into the forearm. The right upper extremity pain was rated at 3 out of 10 and dull. The physical exam of the cervical spine noted full range of motion with mild pain with chin to ceiling movement. The bilateral shoulders were positive for Neer's sign at 90 degrees crossover impingement tests, positive Apley's, positive Hawkins-Kennedy test and weak abduction against resistance. The lumbar spine flexion was 35 degrees of 90, right and left lateral flexion 15 degrees of 25. The toe/heel walking was positive and there was paraspinal tenderness to percussion. The treatment plan included prescriptions for Tramadol and Cyclobenzaprine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50mg Qty 360: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: The patient presents with pain affecting the bilateral shoulder, cervical & lumbar spine. The current request is for Tramadol 50mg Qty 360. The treating physician states, "Tramadol 50mg, 2, b.i.d., prn." The treating physician also documents that the patient rated their pain as 6-7/10 and that the patient has been taking this medication since at least 4/13/15. (126, 150B) For chronic opiate use, the MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and aberrant behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In this case, the treating physician has not documented analgesia, if the patient is able to perform any ADLs, if the patient had any adverse side effects, or if the patient had any aberrant behavior. The current request is not medically necessary and the recommendation is for denial.

Cyclobenzaprine 10mg #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42.

Decision rationale: The patient presents with pain affecting the bilateral shoulder, cervical & lumbar spine. The current request is for Cyclobenzaprine 10mg #180. The treating physician states, "Cyclobenzaprine 10mg, 1, b.i.d., prn." (135B) The MTUS guidelines state, "Recommended as an option, using a short course of therapy. Treatment should be brief." In this case, the treating physician documents that the patient has been taking this medication since at least 4/13/15 and has not documented if the patient has had any decrease in pain with this medication. Additionally, the MTUS guidelines only recommend this medication for short term usage of 2-3 weeks. The current request is not medically necessary and the recommendation is for denial.