

Case Number:	CM13-0005619		
Date Assigned:	06/06/2014	Date of Injury:	01/14/2002
Decision Date:	07/23/2014	UR Denial Date:	07/26/2013
Priority:	Standard	Application Received:	08/01/2013

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 Emergency Medicine, 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:

Patient with reported date of injury on 1/14/2002. Mechanism of injury is described as a L shoulder injury while lifting boxes. Diagnosis of L shoulder impingement, L shoulder myofascial pain and multiple surgeries to affected shoulder. Multiple medical records from primary treating physician was reviewed. Last available report available until 5/5/14. However, most recent records are not relevant to this review. The original request for submitted prior to 7/26/13. Records up to 9/25/13 was reviewed for some additional data. Patient complains of L shoulder and low back pain. Pain has chronic pain syndrome and myofascial pain syndrome. Pain is 5/10. Objective exam on record is limited. Only mentions that exam is normal with no distress and no spasms noted. It states multiple trigger points in neck and lower back. There is no detailed shoulder exam provided on record on 9/25/13, 9/11/13, 8/28/13, 8/11/13 and 7/16/13. Report on 8/28/13 reports claim that the trigger point injection and Toradol shots were to improve "function" that the treating physician has decided to define as sleep, "happiness" and "relationship function". Patient is apparently receiving Toradol and trigger point shots every 2 weeks. No other advance imaging or testing were provided. Urine toxicology screen on 8/27/13 was positive for opiates which is appropriate for patient's norco use. Medication at time of review is prilosec, cymbalta, elavil, lexapro, flector patch, norco, imitrex, lisinopril, trilopix, abilify, loratidine, zanaflex and gabapentin. Utilization review is for Zanaflex 4mg #30 (retrospective), gabapentin 400mg #30, Cymbalta 60mg #30 (Retrospective), Toradol 60mg injection (Retrospective) and Trigger point injection (retrospective).

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE ZANAFLEX 4 MG. QTY: 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodics Drugs Page(s): 66.

Decision rationale: Zanaflex(Tizanidine) is an anti-spasmodic FDA approved for muscle spasms. It has some evidence to support its off-label use in myofascial pain syndrome. However, the treating physician has failed to provide documentation of benefit from Zanaflex. Patient has no documented muscle spasms. Patient also has been on Zanaflex chronically and there is no documentation of improvement in report on pain. Since patient has no documented improvement in pain with an off-label use of Zanaflex, Zanaflex is not medically necessary.

RETROSPECTIVE GABAPENTIN 400 MG. QTY: 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs(AEDs) Page(s): 18-19.

Decision rationale: Gabapentin(Neurontin) is an anti-epileptic drug with efficacy in neuropathic pain. Patient has no documentation of any neuropathic pain and has no evidence to support its use in shoulder pain. There is some evidence that it may be useful in fibromyalgia but patient does not have that diagnosis. Patient has also been on this medication for several years with no documentation improvement in pain. Patient does not meet any indication for use of Neurontin and it is therefore not medically necessary.

RETROSPECTIVE CYMBALTA 60 MG. QTY: 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43-44.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine(Cymbalta Page(s): 43-44.

Decision rationale: Duloxetine(Cymbalta) is a selective serotonin reuptake inhibitor(SNRI) with efficacy in neuropathic pain. Patient has no documentation of any neuropathic pain and has no evidence to support its use in shoulder pain. There is some evidence that it may be useful in fibromyalgia but patient does not have that diagnosis. Patient has also been on this medication for several years with no documentation improvement in pain. Patient does not meet any indication for use of Cymbalta and it is therefore not medically necessary.

RETROSPECTIVE TORADOL 60 MG. INJECTION QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 72.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list and adverse effects Page(s): 72.

Decision rationale: Ketorolac is a Non-steroidal Anti-inflammatory drug(NSAID) that has significant side effects. As per MTUS Chronic pain guidelines, Ketorolac(Toradol) is not indicated for minor or chronic pain. Patient is receiving a ketorolac shot every 2weeks for chronic pains. The use of ketorolac for a chronic pain condition is an off label use contravening FDA labeling and has significant risk to the health of the patient. The use of Toradol injection is not medically appropriate and not medically necessary.

RETROSPECTIVE TRIGGER POINT INJECTION QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 122.

Decision rationale: Trigger Point Injections may be recommended for myofascial pain syndrome if patient meets criteria as set by MTUS Chronic pain guidelines. However, the documentation reports that patient fails to meet repeated Trigger Point Injections. Patient has reported 50% improvement in pain after injection, however this does not last for the required 6weeks after injection and there is no documentation of actual functional improvement as defined by the MTUS. Patient also fails criteria of no more than an injection every 2months. Patient is receiving trigger point injections every 2weeks despite not meeting evidence based guidelines. Trigger Point Injections is not medically appropriate or necessary.