

Case Number:	CM14-0009296		
Date Assigned:	02/21/2014	Date of Injury:	07/15/2004
Decision Date:	06/24/2014	UR Denial Date:	12/24/2013
Priority:	Standard	Application Received:	01/23/2014

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 & Rehabilitation, has a subspecialty in Interventional Spine 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:

This patient is a 52-year-old female with date of injury of 07/15/2004. Per treating physician's report 12/06/2013, the patient presents with chronic right shoulder pain. Pain increased since last visit, activity level decreased. Current listed medications include Lidoderm 5% patches, ThermaCare heat wrap, nortriptyline before bedtime, Butrans, Ativan, and bupropion. MRI of the shoulders from 2009 were reviewed by the treating physician that showed tendinopathies, ganglion cyst, AC joint degenerative changes, evidence of acromioplasty and no rotator cuff tear. Diagnosis is shoulder pain and muscle spasm. Recommendations were for acupuncture that had been helpful in the past, "pain medication regimen is helpful to decrease patient's pain and increased functional status". Under medications, the patient was to continue nortriptyline which patient reports were very effective in managing muscle spasms, continue Lidoderm patches for topical pain relief.

IMR ISSUES, DECISIONS AND RATIONALES

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

LIDODERM 5% PATCH (700 MG PATCH/PATCH TO SKIN DAILY #30): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines MTUS has the following regarding lidoderm patches: L.

Decision rationale: This patient presents with chronic shoulder pain bilaterally. The treating physician has requested the continued use of Lidoderm 5% patches. However, MTUS Guidelines provide specific discussion regarding the Lidoderm patches. It is only recommended for neuropathic pain, and peripheral localized pain. ODG Guidelines provide a better discussion stating that topical lidocaines may be recommended for "localized neuropathic pain" after there has been evidence of a trial of first-line therapy. In this patient, there is no documentation of neuropathic pain. The patient has musculoskeletal nociceptive pain from chronic shoulder condition. Recommendation is for denial.

THERMACARE HEATWRAP (APPLY ONE PATCH AS NEEDED AS DIRECTED #30):
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM, CHAPTER 12, LOW BACK COMPLAINTS, 300

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG guideline under Shoulder thermotherpay Under study. For several physical therapy interventions and indications (eg, thermotherapy using heat, therapeutic exercise, massage, electrical stimulation, mechanical traction), there was a lack of evidence regarding efficacy. (Philadelphia, 2001)

Decision rationale: This patient presents with chronic bilateral shoulder pains. The treating physician has asked for ThermaCare heat wrap. ODG Guidelines states under Thermotherapy, "under the study, for several physical therapy interventions and indications (e.g. themotherapy using heat, therapeutic exercise, massage, electrical stimulation, mechanical traction), there was a lack of evidence regarding efficacy. ODG Guidelines states for lumbar spine that a number of studies show continuous low level heat wrap therapy may be effective for treating low back pain. For lumbar spine pain, ThermaCare heat wrap is more effective than other types. However, this patient does not present with low back pain but with bilateral shoulder pains for which thermotherapy is not recommended. Recommendation is for denial.

NORTRIPTYLINE HCL 10 MG CAP (TAKE 1-2 CAPSULES PO QHS PM #60):
Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ANTIDEPRESSANTS FOR CHRONIC PAIN,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines MTUS on Antidepressants Page(s): 13-15.

Decision rationale: This patient presents with bilateral shoulder pain. The request is for Nortriptyline 10 mg to be used for the patient's muscle spasms and sleep. MTUS Guidelines support use of antidepressants particularly the tricyclic antidepressants for chronic pain and depression. This patient presents with chronic bilateral shoulder pain and sleep difficulties for which Nortriptyline is indicated. Treating physician documents that the use of this medication does help with the patient's sleep and spasms. The request for Nortriptyline HCL 10mg is medically necessary.