

Case Number:	CM14-0108133		
Date Assigned:	08/01/2014	Date of Injury:	08/01/2002
Decision Date:	10/29/2014	UR Denial Date:	06/27/2014
Priority:	Standard	Application Received:	07/11/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine, and is licensed to practice in New Jersey. 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:

The patient is a 56 year old woman who sustained a work-related injury on August 1, 2002. She subsequently developed chronic neck and shoulder pain. In a report dated May 15, 2014, the patient complained of persistent neck and shoulder pain. She stated that without medication, her pain level is about 8/10 and with Vicodin, it improved to 6/10. She used TENS unit every other day or so at least. They did provide significant pain reduction. She was treated with Prilosec for her stomach irritation caused by Naproxen. She used Zanaflex for her muscle spasms. On examination, the patient had cervical tenderness with reduced range of motion. Neurologically, she is intact. She demonstrated normal gait stance and she is strong in the legs. The patient was diagnosed with chronic pain syndrome with pain in the shoulder, neck, thoracic, low back, and right posterior thigh; symptoms are suggestive of fibromyalgia; chronic right shoulder pain. MRI from November 4, 2011 showed intrasubstance partial tear at the supraspinatus with subcortical bone edema at the greater tuberosity. The provider requested authorization to use NAPROXEN, ZANAFLEX, LIDODERM PATCHES, and AMITRIPTYLINE.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETRO NAPROXEN 550 MG, # 60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen Page(s): 66.

Decision rationale: According to MTUS guidelines, Chronic Pain Medical Treatment Guidelines chapter, Nonselective NSAIDS section, Naproxen is indicated for pain management of chronic neck or back pain. According to the patient file, there is no documentation of flare of osteoarthritis pain. There is no documentation of efficacy of previous use of Naproxen. In addition, the medication caused GI upset requiring the use of Prilosec. Therefore, the prescription of 60 Naproxen 550mg is not medically necessary.

RETRO ZANAFLEX 4 MG, # 60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: According to MTUS guidelines, a non-sedating muscle relaxants is recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic lumbosacral pain. Efficacy appears to diminish over time and prolonged use may cause dependence. The patient in this case developed continuous pain, does not have clear exacerbation of back or neck pain and spasm and the prolonged use of Zanaflex is not justified. Furthermore, there is no clear evidence of chronic myofascial pain, spasm and no documentation of the patient's objective response to this medication. There is no determination how long the medication will be used. Therefore, the request for Zanaflex 4mg #60 is not medically necessary.

LIDODERM PATCHES 5 %, # 60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56.

Decision rationale: According to MTUS guidelines, Lidoderm is the brand name for a lidocaine patch produced by Endo Pharmaceuticals. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin. In this case, there is no documentation that the patient developed neuropathic pain that did not respond to first line therapy and the need for Lidoderm patch is unclear. In addition, there is not significant documentation of continuous improvement. Therefore, the prescription of Lidoderm patch 5% is not medically necessary.

RETRO AMITRIPTYLINE 10 MG, # 120: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressant for chronic pain Page(s): 13.

Decision rationale: According to MTUS guidelines, tricyclics (Amitriptyline is a tricyclic antidepressant) are generally considered as a first a first line agent for pain management unless they are ineffective, poorly tolerated or contraindicated. According to the patient file, there was no documentation of a specific objective neuropathic pain condition occurring on physical examination. There is no documentation of diabetic neuropathy or post-herpetic neuralgia. Based on the above, the prescription for Amitriptyline 10mg # 120 is not medically necessary.