

Case Number:	CM14-0026443		
Date Assigned:	06/16/2014	Date of Injury:	08/20/2012
Decision Date:	08/12/2014	UR Denial Date:	01/29/2014
Priority:	Standard	Application Received:	03/03/2014

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 and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 injured worker is a 34-year-old female who reported an injury on 08/20/2012. The mechanism of injury was not provided for clinical review. The diagnoses included left shoulder impingement status post arthroscopic extensive debridement, cervical sprain/strain with trigger points along the trapezius and shoulder girdle, element of stress, depression, weight gain of approximately 10 to 15 pounds, sexual dysfunction, sleep dysfunction, hypertension. Previous treatments included physical therapy and injections, MRI, surgery, medications, and TENS unit. Within the clinical note dated 03/18/2014, it was reported the injured worker complained of right shoulder pain. She complained of stiffness along the neck and shoulder as well as limited range of motion bilaterally. Upon physical examination of the left shoulder, the provider noted range of motion was abduction at 60 degrees and on the right 110 degrees. The injured worker had tenderness along the rotator cuff and biceps tendon and mild tenderness along the AC joint. The injured worker had a positive impingement on the left and mild on the right, positive Hawkins on the left and mildly positive on the right, and a positive Speed's test on the left and mildly positive on the right. The injured worker had tenderness along the trapezius and shoulder girdle bilaterally. The provider requested for Norco for pain, Flexeril for muscle spasms, Ultram for pain, and Terocin patch. The request for authorization was submitted however, it was not dated.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO 10/325MG X 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 Opioids, criteria for use, On-Going Management Page(s): 78.

Decision rationale: The injured worker complained of right shoulder pain. She complained of stiffness along the neck and shoulder as well as limited range of motion bilaterally. The California MTUS Guidelines recommend ongoing review and documentation of functional status, pain relief, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. The provider did not document an adequate and complete pain assessment within the documentation. There is lack of documentation indicating the medication had been providing objective functional benefit and improvement. Additionally, the use of a urine drug screen was not provided for clinical review. The request submitted failed to provide the frequency of the medication. The injured worker has been utilizing the medication since at least 08/2013. Therefore, the request is not medically necessary.

FLEXERIL 7.5MG X 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): 63,64.

Decision rationale: The injured worker complained of right shoulder pain. She complained of stiffness along the neck and shoulder as well as limited range of motion bilaterally. The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short-term treatment of acute exacerbation in patients with chronic low back pain. The guidelines note the medication is not recommended to be used for longer than 2 to 3 weeks. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most low back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement. There is lack of objective findings indicating the injured worker had muscle spasms. The injured worker has been utilizing the medication for an extended period of time since at least 08/2013 which exceeds the recommended guidelines of short-term use for 2 to 3 weeks. Additionally, the request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

ULTRAM 50MG X 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 Opioids, criteria for use, On-Going Management Page(s): 78.

Decision rationale: The injured worker complained of right shoulder pain. She complained of stiffness along the neck and shoulder as well as limited range of motion bilaterally. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment for issues of abuse, addiction, or poor pain control. The provider did not document an adequate and complete pain assessment within the documentation. There is lack of documentation indicating the medication had been providing objective functional benefit and improvement. The injured worker has been utilizing the medication since at least 08/2013. Additionally, the use of a urine drug screen was not provided for clinical review. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

TEROCIN PATCH X 20: 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 Topical NSAIDs Page(s): 111-112.

Decision rationale: The injured worker complained of right shoulder pain. She complained of stiffness along the neck and shoulder as well as limited range of motion bilaterally. The California MTUS Guidelines note topical NSAIDs are recommended for the use of osteoarthritis and tendonitis, in particular that of the knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for short-term use of 4 to 12 weeks. There is little evidence to utilize topical NSAIDs for the treatment of osteoarthritis of the spine, hip, or shoulder. Tercin patch contains Lidocaine and menthol. Topical Lidocaine is recommended for neuropathic pain and localized peripheral pain after there has been evidence of first line therapy. Topical Lidocaine in the formulation of a dermal patch has been designated for orphan status by the FDA for neuropathic pain. There is lack of documentation indicating the injured worker was treated for or diagnosed with osteoarthritis or tendonitis. There is lack of documentation indicating the injured worker tried and failed on first line agents for the management of neuropathic pain. Additionally, the injured worker has been utilizing the medication since at least 08/2013 which exceeds the guideline recommendations of short-term use of 4 to 12 weeks. The request submitted failed to provide the treatment site. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.