

Case Number:	CM14-0040432		
Date Assigned:	06/16/2014	Date of Injury:	08/03/2011
Decision Date:	07/17/2014	UR Denial Date:	03/04/2014
Priority:	Standard	Application Received:	03/07/2014

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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 52-year-old male with an 8/3/11 date of injury and status post right shoulder surgery (undated). At the time (2/13/14) of request for authorization for Percocet 10/325mg #60, Flexeril 10mg #60, and Lidoderm patch 5% #90 with 3 refills, there is documentation of subjective (right shoulder pain, right upper extremity pain, headaches, burning neck pain down to the arms, and mid back pain; rated as a 9 out of 10 without medications and 3-4 out of 10 with medications) and objective (diffuse tenderness to palpation over the right shoulder and right upper extremity, limited range of motion of the right shoulder, elbow and wrist, decreased strength in the right upper extremity, and hypersensitivity over the entire right upper extremity) findings, current diagnoses (right shoulder pain, chronic pain syndrome, right elbow pain, right wrist pain, reflex sympathetic dystrophy of the upper extremity, and allodynia of the right upper extremity), and treatment to date (Percocet since at least 12/6/13 with pain relief and increase in activities of daily living, Flexeril since at least 1/16/14 with pain relief, Lidoderm patch since at least 12/19/13 with neuropathic pain relief, and ongoing therapy with Ultram, Norco, Gabapentin, and Amitriptyline). In addition, medical report identifies a signed opioid contract. Regarding Flexeril 10mg #60, there is no documentation of short-term (less than two weeks) treatment and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of use of Flexeril. Regarding Lidoderm patch 5% #90 with 3 refills, there is no documentation that a trial of first-line therapy (tri-cyclic anti-depressants or gabapentin) has failed and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of use of Lidoderm patch.

IMR ISSUES, DECISIONS AND RATIONALES

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

PERCOCET 10/325MG #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria For Use of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of right shoulder pain, chronic pain syndrome, right elbow pain, right wrist pain, reflex sympathetic dystrophy of the upper extremity, and allodynia of the right upper extremity. In addition, given documentation of a signed opioid contract, there is documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Furthermore, given documentation of ongoing treatment with Percocet since at least 12/6/13 with pain relief and increase in activities of daily living, there is documentation of functional benefit or improvement as an increase in activity tolerance as a result of use of Percocet. Therefore, based on guidelines and a review of the evidence, the request for Percocet 10/325mg #60 is medically necessary.

FLEXERIL 10MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain).

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that Flexeril is recommended for a short course of therapy. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended as a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Within the

medical information available for review, there is documentation of diagnoses of right shoulder pain, chronic pain syndrome, right elbow pain, right wrist pain, reflex sympathetic dystrophy of the upper extremity, and allodynia of the right upper extremity. In addition, there is documentation of chronic pain. However, there is no documentation of acute exacerbations of chronic pain. In addition, given documentation of ongoing treatment with Flexeril since at least 1/16/14, there is no documentation of short-term (less than two weeks) treatment. Furthermore, despite documentation of pain relief with Flexeril, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of use of Flexeril. Therefore, based on guidelines and a review of the evidence, the request for Flexeril 10mg #60 is not medically necessary.

LIDODERM PATCH 5% #90 WITH 3 REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56-57.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain after there has been evidence that a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica) has failed, as criteria necessary to support the medical necessity of a lidocaine patch. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of right shoulder pain, chronic pain syndrome, right elbow pain, right wrist pain, reflex sympathetic dystrophy of the upper extremity, and allodynia of the right upper extremity. In addition, there is documentation of neuropathic pain. However, given documentation of ongoing treatment with Gabapentin and Amitriptyline, there is no documentation that a trial of first-line therapy (tri-cyclic anti-depressants or gabapentin) has failed. In addition, despite documentation of ongoing treatment with Lidoderm patch since at least 12/19/13 with neuropathic pain relief, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of use of Lidoderm patch. Therefore, based on guidelines and a review of the evidence, the request for Lidoderm patch 5% #90 with 3 refills is not medically necessary.