

Case Number:	CM14-0071273		
Date Assigned:	07/14/2014	Date of Injury:	07/13/1998
Decision Date:	08/14/2014	UR Denial Date:	05/02/2014
Priority:	Standard	Application Received:	05/16/2014

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 Neurological Surgery 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:

The records, presented for review, indicate that this 53-year-old female was reportedly injured on July 13, 1998. The mechanism of injury was noted as a blunt force trauma to the head. The most recent progress note, dated June 10, 2014, indicated that there were ongoing complaints of neck and right shoulder pains. The physical examination demonstrated a decrease in cervical spine range of motion, a decrease in left shoulder range of motion, no specific tenderness to palpation and no particular motor function loss. Deep tendon reflexes were equal and symmetric. A full range of motion was noted to the distal upper extremity. Diagnostic imaging studies (EMG) noted a normal electrodiagnostic study of both upper extremities. Previous treatment included shoulder arthroscopy, physical therapy, occipital nerve root blocks, a cervical fusion and multiple medications. A request was made for multiple medications and was not certified in the pre-authorization process on May 2, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone / APAP 10 / 325 mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 74-78 of 127.

Decision rationale: When considering the date of injury and the multiple interventions completed, the electrodiagnostic assessment did not identify any particular pathology taking into account the most recent physical examination. There was no clear clinical indication for the continued use of narcotic analgesics at the time. The MTUS supports the use of this medication for the short-term management of moderate to severe breakthrough pain. There were complaints of pain ,but there was no objective data to explain the complaints. Furthermore, there was no documentation of significant pain relief or functional improvement. As such, the medical necessity for this narcotic analgesic has not been established.

Lidocaine pad 5%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 56 of 127.

Decision rationale: The MTUS supports the use of topical lidocaine for individuals with neuropathic pain who have failed treatment with first-line therapy including antidepressants or anti-epileptic medications. Based on the clinical documentation provided, particularly noting the wholly normal electrodiagnostic assessment, there was no data presented to suggest a medical necessity for this patch.

Carisoprodol 350 mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 29 of 127.

Decision rationale: The MTUS specifically recommends against the use of Soma and indicates that it is not recommended for long-term use. Based on the clinical documentation provided, the clinician did not provide rationale for deviation from the guidelines. As such, with the very specific recommendation of the MTUS against the use of this medication, the medical necessity for this preparation has not been established.

Voltaren gel 1%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 111,112 of 127.

Decision rationale: Voltaren gel is a topical NSAID indicated for the relief of osteoarthritic pain of the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. Outside of the treatment of osteoarthritis, there was no other clinical indication for the use of this medication. There was no documentation of any efficacy or utility, improvement in symptomology or medical necessity for this topical preparation.