

Case Number:	CM14-0076570		
Date Assigned:	07/18/2014	Date of Injury:	11/14/2011
Decision Date:	10/15/2014	UR Denial Date:	05/06/2014
Priority:	Standard	Application Received:	05/27/2014

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 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 patient is a 58 year old male who sustained an industrial injury on 11/14/2011. He is status post total right shoulder athroplasty in August 2013. According to the 4/14/2014 secondary treating physician's progress report by [REDACTED], the patient reports he has no pain, he just has difficulty moving his arm. Objectively, limited forward flexion and abduction and slight weakness to resistance of these motions is noted. The patient sees [REDACTED] or [REDACTED], who thinks his shoulder is worse, however, the patient states it is not worse, "I have no pain, and although my motion is limited, I can live with that". He is not interested in any further procedures to the shoulder. His low back is bothersome. Medications are continued. The 4/14/2014 Urine Drug Screen (UDS) is positive for Tramadol. The 4/15/2014 PTP PR-2 indicates the patient complains of constant low back and right shoulder pain with decreased ROM. Objectively, tenderness at right shoulder and L/S with spasm, decreased ROM, weakness, and + SLR are listed. Diagnoses are lumbago and shoulder pain. According to the 6/3/2014 PR-2, the patient complains of worse low back pain with radiation into the lower extremities, rated 7/10, unchanged right shoulder pain rated 8/10. Objective findings indicate tenderness with spasm, normal and intact sensation and strength, guarded and restricted Range of Motion (ROM) in the lumbar and right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbip/Capsai IN KN Oil #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: According to the CA MTUS guidelines, topical analgesics are considered to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines state capsaicin is only recommended as an option in patients who have not responded or are intolerant to other treatments. The patient is status post right shoulder arthroplasty in 8/2013, and is diagnosed with lumbago and shoulder pain. Review of the medical records document the patient's treatment includes oral medications. In addition, the guidelines state there is little evidence to utilize topical Non-Steroidal Anti-Inflammatory Drugs (NSAID)'s for treatment of osteoarthritis of the spine or shoulder. The medical necessity of this compound has not been established. The request is not medically necessary and appropriate.

Lidocaine/Hyaluronic (Patch) #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The CA MTUS state only Lidocaine in the formulation of Lidoderm patch may be considered for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or Serotonin-Norepinephrine Reuptake Inhibitors (SNRI) anti-depressants or an Anti-Epilepsy Drugs (AEDs) such as gabapentin or Lyrica). The guidelines state no other commercially approved topical formulations of lidocaine are indicated for neuropathic pain. Only FDA-approved products are currently recommended. Topically applied lidocaine is not recommended for non-neuropathic pain. Furthermore, the medical records do not provide a valid rationale this compound product to contain hyaluronic. Per the guidelines, many agents are compounded as mono-therapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, -adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). There is little to no research to support the use of many of these agents. The medical records do not establish this topical patch is appropriate and medically necessary for this patient. The request is not medically necessary and appropriate.