

Case Number:	CM14-0186348		
Date Assigned:	11/14/2014	Date of Injury:	08/17/2012
Decision Date:	01/05/2015	UR Denial Date:	10/20/2014
Priority:	Standard	Application Received:	11/10/2014

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 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 injured worker is a 53-year-old female who reported an injury on 08/17/2012. The mechanism of injury was not documented within the clinical notes. The injured worker's diagnoses were noted to include chronic pain syndrome, right shoulder pain, myalgia, and rotator cuff syndrome. The injured worker's past treatments included physical therapy. There was no official diagnostic imaging studies submitted for review. The injured worker's surgical history included right shoulder arthroscopy. The subjective complaints on 10/23/2014 included right shoulder pain. The physical exam findings noted right shoulder range of motion, flexion 130 degrees, abduction 120 degrees. The grip strength was noted 5/5. The injured worker's medications were noted to include Ibuprofen, Hydrocodone/Acetaminophen, Flexeril, Ambien, and Lidoderm patches. The treatment plan was to refill the medications. A request was received for Flexeril 7.5 mg, Norco 10/325, and Lidoderm 5% patches. The rationale for the request was to relieve the patient's pain. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexeril 7.5mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 54.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 64.

Decision rationale: The request for Flexeril 7.5mg, #60 is not medically necessary. The California MTUS Guidelines recommend Flexeril for a short course of therapy. The guidelines recommend Flexeril not to be used longer than 3 weeks. As the request exceeds the guideline recommendation of 3 weeks, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

Norco 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Ongoing Management Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 78.

Decision rationale: The request for Norco 10/325mg #60 is not medically necessary. The California MTUS Guidelines state 4 domains that have been proposed as most relevant for monitoring of pain patients on opioids. These include pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant or nonadherent drug related behaviors. The clinical notes did document quantified numerical pain relief. However, there was a lack of documentation of side effects, physical and psychosocial functioning, and aberrant behavior. Furthermore, there was no current drug screen submitted to assess for aberrant behavior. Additionally, the request as submitted did not provide a medication frequency. As adequate documentation was not submitted of side effects, physical and psychosocial functioning, and aberrant behavior, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

Lidoderm 5% patch #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 57-58.

Decision rationale: The request for Lidoderm 5% patch #60 is not medically necessary. The California MTUS Guidelines state that Lidoderm patch is not recommended for first line treatment and is only FDA approved for postherpetic neuralgia. There is a lack of documentation in the clinical notes that the patient has postherpetic neuralgia. In the absence of postherpetic neuralgia, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.