MAXIMUS Federal Services

Case Number:	CM15-0186841		
Date Assigned:	09/28/2015	Date of Injury:	12/02/2012
Decision Date:	11/06/2015	UR Denial Date:	09/15/2015
Priority:	Standard	Application Received:	09/22/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Maryland
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular Medicine

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 69 year old male who sustained an industrial injury on 12-02-2012. A review of the medical records indicated that the injured worker is undergoing treatment for the left shoulder rotator cuff syndrome. According to the treating physician's progress report on 08-31-2015, the injured worker continues to experience left shoulder pain. Inspection noted normal contour with tenderness to palpation and decreased range of motion throughout. Abduction was noted at 50-60 degrees. Motor and sensation were intact. Prior treatments included diagnostic testing, acupuncture therapy, transcutaneous electrical nerve stimulation (TEN's) unit, shoulder injection, physical therapy, home exercise program and medications. The injured worker would like to avoid surgical intervention. Current medications were listed as Celebrex, Lyrica, Lidoderm patch and Voltaren gel. Treatment plan consists of continuing with home exercise program and on 09-07-2015 the provider requested authorization for Celebrex 200mg #60 and Lidoderm 5% patches #30. On 09-15-2015 the Utilization Review determined the requests for Celebrex 200mg #60 and Lidoderm 5% patches #30 were not certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Celebrex 200mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Anti-inflammatory medications, NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, GI symptoms & cardiovascular risk, NSAIDs, hypertension and renal function, NSAIDs, specific drug list & adverse effects.

Decision rationale: Celebrex 200mg #60 is not medically necessary per the MTUS Guidelines. The MTUS states that Celebrex may be considered if the patient has a risk of GI complications, but not for the majority of patients. The recommended dose of Celebrex is 200 mg a day (single dose or 100 mg twice a day). The guidelines state that NSAIDS are recommended as an option at the lowest dose for short-term symptomatic relief of chronic low back pain, osteoarthritis pain, and for acute exacerbations of chronic pain. The request for 200mg #60 is not medically necessary as this dose exceeds the recommended dose of 200mg daily. Furthermore, there is no documentation that the patient has failed traditional first line NSAIDs. The request for Celebrex is not medically necessary.

Lidoderm 5% patches #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Lidoderm (lidocaine patch).

Decision rationale: Lidoderm 5% patches #30 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines The guidelines state that topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. The documentation does not indicate failure of first line therapy for peripheral pain. The documentation does not indicate a diagnosis of post herpetic neuralgia. For these reasons the request for Lidoderm Patch 5% is not medically necessary.