

<b>Case Number:</b>	CM15-0207163		
<b>Date Assigned:</b>	10/23/2015	<b>Date of Injury:</b>	03/04/2015
<b>Decision Date:</b>	12/04/2015	<b>UR Denial Date:</b>	09/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/21/2015

### 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: Florida

Certification(s)/Specialty: Family Practice

### 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 sustained an industrial injury on 3-4-15. The injured worker was diagnosed as having right forearm wrist burn grade II to III, right volar forearm contracture, right adhesive capsulitis, right upper extremity complex regional pain syndrome and right rib strain. Subjective findings (6-10-15, 7-1-15) indicated right upper extremity pain that radiates into the medial aspect of the elbow axilla and up into the anterior aspect of the shoulder and scapula region. Objective findings (6-10-15, 7-1-15) revealed allodynia over the right forearm axilla and anterior shoulder and right shoulder range of motion is guarded due to pain. As of the PR2 dated 8-11-15, the injured worker reports right upper extremity pain that is worse with contact and activity. She has returned to work on 7-27-15 and rates her pain 7-9 out of 10 without medications and 4 out of 10 with medications. Objective findings include allodynia of the right volar distal forearm and wrist as well as the anterior shoulder. Current medications include Butrans patch, Lidocaine patch (since at least 6-10-15), Lyrica and Tylenol #4. Treatment to date has included a [REDACTED] sleeve. The Utilization Review dated 9-21-15, non-certified the request for Tylenol 30-300mg #30 x 2 refills, Nabumetone 750mg #60 x 2 refills and Lidocaine 4% patch #10 x 2 refills.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Tylenol 30/300mg #30 refills 2:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

**Decision rationale:** In accordance with California MTUS guidelines, narcotics for chronic pain management should be continued if "(a) If the patient has returned to work, (b) If the patient has improved functioning and pain." MTUS guidelines also recommend that narcotic medications only be prescribed for chronic pain when there is evidence of a pain management contract being upheld with proof of frequent urine drug screens. Regarding this patient's case, there is no objective evidence of functional improvement. Likewise, this requested chronic narcotic pain medication is not medically necessary.

**Nabumetone 750mg #60 refills 2:** 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): NSAIDs (non-steroidal anti-inflammatory drugs).

**Decision rationale:** In accordance with California MTUS guidelines, NSAIDS are recommended as an option for short-term symptomatic relief. These guidelines state, "A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics." The MTUS guidelines do not recommend chronic use of NSAIDS due to the potential for adverse side effects. Likewise, this request for Nabumetone is not medically necessary.

**Lidocaine 4% patch #10 refills 2:** 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:** In accordance with California Chronic Pain MTUS guidelines, Lidoderm (topical Lidocaine) may be recommended for localized peripheral pain after there has been a trial of a first-line treatment. The MTUS guideline specifies "tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica" as first line treatments. The provided documentation does not show that this patient was tried and failed on any of these recommended first line treatments.

Topical Lidoderm is not considered a first line treatment and is currently only FDA approved for the treatment of post-herpetic neuralgia. Likewise, for the aforementioned reasons, the requested Lidoderm Patches are not medically necessary.