

<b>Case Number:</b>	CM15-0089620		
<b>Date Assigned:</b>	05/14/2015	<b>Date of Injury:</b>	10/18/2013
<b>Decision Date:</b>	06/18/2015	<b>UR Denial Date:</b>	04/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/11/2015

### 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: New York, West Virginia, Pennsylvania  
 Certification(s)/Specialty: Emergency 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 44 year old, male who sustained a work related injury on 10/18/13. The diagnoses have included right shoulder impingement syndrome, rotator cuff tear and lumbar spine herniated disc. The treatments have included oral medications, medicated pain cream, physical therapy, injections, heat/ice therapy and rest. In the Re-Examination Report dated 3/30/15, the injured worker complains of progressive right shoulder and lumbar spine pain. He is doing "poorly." He has tenderness about his right shoulder and lumbar spine. The treatment plan is refill prescriptions for oral medications and for medicated pain cream.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Gabapentin / Pyrodoxine 250mg/10mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
 Gabapentin Page(s): 18-19.

**Decision rationale:** Gabapentin is recommended for treatment of diabetic neuropathy and postherpetic neuralgia and is first line treatment for neuropathic pain. In this case, the patient does not have diabetic neuropathy and/or postherpetic neuralgia. In addition, there is no documentation of functional improvement with prior use of gabapentin. The request for 250/10 mg is not medically appropriate and necessary.

**Flurb / Cyclo / Ment 180grams:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics.

**Decision rationale:** Guidelines state that topical analgesics are largely experimental and primarily recommended for neuropathic pain. In this case, there is little to no research to support the use of these agents. Since topical medications have not been shown to be effective, the request for Flurb/Cyclo/Ment 180 grams is not medically appropriate and necessary.

**Orphenadrine 50mg / Caffeine 10mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants.

**Decision rationale:** Guidelines support short term use of muscle relaxants as a second line option in the management of acute pain and acute exacerbations of chronic pain. In this case, the patient has chronic pain and there is no documentation of an acute exacerbation. The request for Orphenadrine/Caffeine 50/10 mg #60 is not medically necessary and appropriate.