

Case Number:	CM14-0147049		
Date Assigned:	09/15/2014	Date of Injury:	08/30/2012
Decision Date:	10/15/2014	UR Denial Date:	08/28/2014
Priority:	Standard	Application Received:	09/10/2014

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 & Rehabilitation and is licensed to practice in California and Washington. 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 55 year old male who reported an injury on 08/30/2012. Mechanism of injury was not provided. The injured worker had diagnoses including right shoulder impingement, ac joint arthritis left shoulder impingement, compensating to the right side. Past treatment included medications, physical therapy, a left shoulder injection of Depo-Medrol/Marcaine on 08/07/2013, a TENS unit trial on 09/-10/2013, use of an H-wave unit, and a home exercise program. Diagnostic studies included an MRI of the right shoulder and x-rays of the right shoulder on 11/12/2013. Surgical history included right shoulder arthroscopy with subacromial decompression and distal clavicle resection on 02/15/2013 and 03/28/2014. The injured work complained of pain and discomfort radiating into the entire right upper extremity on 07/14/2014. The injured worker reported very little improvement after surgery on 03/28/2014. The injured worker had symptoms of pain and weakness with forward elevation, internal rotation and reaching behind the back. The physical examination revealed active range of motion to approximately 50% of normal with significant resistance and guarding to further passive range of motion although in the supine position, the injured worker was noted to have full external rotation. Medications were not provided. The treatment plan was for Voltaren Gel 1%. The rationale for the request was not submitted. The request for authorization form was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Gel 1%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 118, 117-119. Decision based on Non-MTUS Citation ODG, Formulary, U.S. Food and Drug Administration

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Topical Analgesics, Page(s): 111-112..

Decision rationale: The injured work complained of pain and discomfort radiating into the entire right upper extremity on 07/14/2014. The injured worker reported very little improvement after surgery 03/28/2014. The California MTUS guidelines note topical NSAIDs are recommended for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder and use with neuropathic pain is not recommended as there is no evidence to support use. The injured worker has right shoulder pain complaints. There is a lack of documentation which indicates the injured worker has osteoarthritis or tendinitis to a joint amenable to topical treatment. Additionally, the request does not indicate the frequency at which the medication is prescribed and the site at which it is to be applied in order to determine the necessity of the medication. Therefore the request for Voltaren gel 1% is not medically necessary.

Lidocaine Pads 5%: Upheld

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

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

Decision rationale: The injured work complained of pain and discomfort radiating into the entire right upper extremity on 07/14/2014. The injured worker reported very little improvement after surgery 03/28/2014. The California MTUS guidelines state, any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. The guidelines recommend the use of Lidocaine 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). Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The requesting physician's rationale for the request is not indicated within the provided documentation. There is a lack of documentation the injured worker has been treated with first line therapy. The request does not specify the location for application of the proposed pad. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. Given the above the request for Lidoderm patches 5% is not medically necessary.

Hydrocodone/APAP 5/325mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Chronic Pain Guide, page(s) 82.

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

Decision rationale: The injured work complained of pain and discomfort radiating into the entire right upper extremity on 07/14/2014. The injured worker reported very little improvement after surgery 03/28/2014. The California MTUS Guidelines indicate opioids showed limited efficacy beyond 16 weeks of use. The guidelines also state ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The guidelines also state the pain assessment should include current pain on a VAS scale, average pain, intensity of pain, or longevity of pain relief. In this case, there is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. There is a lack of documentation of a measured assessment of the injured worker's pain level. There is a lack of documentation indicating urine drug screening has been performed. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. Therefore, the request for Hydrocodone/APAP 5/325mg is not medical necessary.