

Case Number:	CM14-0158760		
Date Assigned:	10/08/2014	Date of Injury:	11/20/2001
Decision Date:	11/04/2014	UR Denial Date:	09/10/2014
Priority:	Standard	Application Received:	09/29/2014

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 Anesthesiologist, has a subspecialty in Pain Medicine and is licensed to practice in California & Nevada. 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 46-year-old female, who reported an injury on 11/20/2001. Mechanism of injury was not provided. The injured worker has diagnoses of chronic left shoulder pain status post subacromial decompression, regional myofascial pain of the left trapezius and levator scapulae, and chronic pain syndrome with both sleep and mood disorder. Past medical treatment included medications, cortisone injections, physical therapy, acupuncture, and TENS unit. Diagnostic testing included an MRI of the left shoulder on 02/23/2007. The injured worker underwent left shoulder sub acromial decompression (date was not provided). The injured worker complained of chronic left shoulder pain on 08/29/2014. The injured worker described pain to be 5/10, the worst pain 8/10 to 9/10. The injured worker stated the pain had increased to the left shoulder in the 6 weeks prior to the visit. The injured worker was waking up more often during the night due to the increased pain. The injured worker described pain that radiated into left neck and down in the left arm intermittently, continuous tingling to the left upper extremity. The physical examination revealed essentially full range of motion to the left shoulder. Medications included citalopram 20 mg, ibuprofen 600 mg, Lidoderm 5% adhesive patch, methocarbamol 500 mg, and Norco 10/325 mg. The treatment plan is for methocarbamol 500 mg #30 with 1 refill and Lidoderm 5% adhesive patch #30 with 1 refill. The rationale for the request was not submitted for review. The Request for Authorization form was submitted on 09/02/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methocarbamol 500mg #30 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Antispasmodics, Page(s): 64.

Decision rationale: The injured worker complained of chronic left shoulder pain on 08/29/2014. The California MTUS Guidelines state that Methocarbamol (muscle relaxer) is recommended for a short course of therapy. This medication is not recommended to be used for longer than 2-3 weeks. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. The guidelines state Methocarbamol is not recommend for chronic pain or to be used for longer than 2-3 weeks. There is lack of documentation stating the length of time the injured worker has been prescribed the requested medication. The frequency of the requested medication was not provided. Therefore the request for Methocarbamol 500mg #30 with 1 refill is not medically necessary.

Lidoderm 5% adhesive patch #30 with 1 refill: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The injured worker complained of chronic left shoulder pain on 08/29/2014. The California Medical Treatment Utilization Schedule (MTUS) Guidelines state that Lidoderm 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). The guidelines note Lidoderm is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. There is a lack of documentation indicating the injured worker has been treated with first line therapy. There is no indication that the injured worker has a diagnosis of post-herpetic neuralgia. There is documentation demonstrating why the injured worker would require a topical patch versus oral medication. 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. Given the above the request for Lidoderm 5% adhesive patch #30 with 1 refill is not medically necessary.