

Case Number:	CM14-0161525		
Date Assigned:	10/07/2014	Date of Injury:	03/20/1999
Decision Date:	12/17/2014	UR Denial Date:	09/24/2014
Priority:	Standard	Application Received:	10/01/2014

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 Occupational Medicine, and is licensed to practice in California. 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:

Injured worker is a male with date of injury 3/20/1999. Per primary treating physician's progress report dated 9/25/2014, the injured worker complains of right shoulder pain. He rates his pain with medications as 8/10 and without medications 9/10. He denies any new problems or side-effects. Quality of sleep is fair. His activity level has decreased. He is taking his medications as prescribed. He states that medications are working well. On examination the injured worker has an unsteady gait and is assisted by the use of a cane. Cervical spine range of motion is restricted with pain. There is hypertonicity and tenderness of the cervical paravertebral muscles on both sides. Spurling's maneuver causes pain in the muscles of the neck, but no radicular symptoms. All upper limb reflexes are equal and symmetric. Tenderness is noted in the trapezius on the right. Inspection of the right shoulder reveals arthroscopic incision. Movements are restricted with inability to perform basic range of motion due to pain. Hawkins test is positive. Shoulder crossover test is positive. On palpation, there is tenderness noted in the right acromioclavicular joint, glenohumeral joint and subdeltoid bursa. Motor testing is limited by pain, with right shoulder external rotation and internal rotation 3/5. Sensory examination reveals normal touch, pain, temperature, deep pressure, vibration, tactile localization and tactile discrimination. Diagnosis is right shoulder pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription of lidoderm 5% patch, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch)Lidocaine, Topical.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine Patch) section Page(s): 56, 57.

Decision rationale: Lidoderm is a Lidocaine patch providing topical Lidocaine. The MTUS Guidelines recommend the use of topical Lidocaine primarily for neuropathic pain when trials of antidepressant and anticonvulsants have failed. There is no clear evidence in the clinical reports that this injured worker has neuropathic pain that has failed treatment with trials of antidepressants and anticonvulsants. This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. The injured worker is not reported or described as having neuropathic pain. There is also no indication that the injured worker has failed treatment with antidepressants and anticonvulsants. The medical reports provided for review do not indicate significant improvement in pain or objective functional improvement with the use of Lidoderm. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. The request for 1 Prescription of Lidoderm 5% patch, #30 is determined to not be medically necessary.

1 Prescription of duragesic 75mcg/hr patch #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids section, Weaning of Medications section Page(s): 74-95, 124.

Decision rationale: The MTUS Guidelines do not recommend the use of Duragesic patch as a first-line therapy. Duragesic is the trade name of a fentanyl transdermal therapeutic system, which releases fentanyl, a potent opioid, slowly through the skin. The FDA-approved product labeling states that Duragesic is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. They do provide guidance on the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. The medical records do not indicate that the injured worker has objective functional improvement or significant reduction in pain with the use of Duragesic patch. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. It is not recommended to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to maintain treatment. The request for 1 Prescription of duragesic 75mcg/hr patch #10 is determined to not be medically necessary.