

Case Number:	CM14-0099810		
Date Assigned:	07/28/2014	Date of Injury:	05/28/2013
Decision Date:	10/09/2014	UR Denial Date:	06/16/2014
Priority:	Standard	Application Received:	06/30/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 patient is a 30-year-old man who sustained a work related injury on May 28, 2013. Subsequently, he developed chronic right shoulder pain. According to a progress report dated April 28, 2014, the patient states that his pain will vary from a 1-2/10 to, at its worst, a 7/10, especially when lifting or performing heavy activities with his right arm. His physical examination, there is a right shoulder swelling with reduced range of motion. Left shoulder forward flexion and abduction were full. Supraspinatus strength testing was negative bilaterally. Bilateral drop arm tests were negative. Neer's and Hawkin's tests were negative in bilateral shoulders. Cross-arm adduction is positive on the right, negative on the left. There is tenderness over the right AC joint. Neurologic examination revealed deep tendon reflexes are equal and symmetric throughout the bilateral upper and lower extremities. 5-/5 strength in the proximal right upper extremity, 5/5 in the distal right upper extremity and throughout the left upper extremity, 5/5 strength throughout the bilateral lower extremities. Sensory examination revealed grossly intact to pinprick and light touch. There was no evidence of sensory dermatomal deficit. The patient was started on two rounds of physical therapy and acupuncture without improvement. The patient was diagnosed with right shoulder pain with a possible acromioclavicular joint dysfunction. The provider requested authorization for Bio Freeze roll and Lidoderm patches.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Bio Freeze roll on gel # 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 11, 112.

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

Decision rationale: According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. There is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. There is no documentation of failure of first line oral medication for the treatment of pain. Therefore, topical analgesic Bio freeze roll is not medically necessary.

Retrospective Lidoderm 5 percent patch 12 hours on, 12 hours off #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 11, 112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines < Lidoderm (lidocaine patch) Page(s): 56.

Decision rationale: According to MTUS guidelines, <<Lidoderm is the brand name for a lidocaine patch produced by [REDACTED]. Topical lidocaine 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>>. In this case, there is no documentation that the patient developed neuropathic pain that did not respond for first line therapy and the need for Lidoderm patch is unclear. There is no documentation of efficacy of previous use of Lidoderm patch. Therefore, the prescription of Lidoderm patch 5% is not medically necessary.