

Case Number:	CM15-0100075		
Date Assigned:	06/02/2015	Date of Injury:	02/11/2014
Decision Date:	06/30/2015	UR Denial Date:	05/22/2015
Priority:	Standard	Application Received:	05/22/2015

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: California
 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:

This 29 year old female sustained an industrial injury to the neck and shoulder on 2/11/14. Previous treatment included magnetic resonance imaging, physical therapy, acupuncture and medications. In a progress note dated 5/1/15, the injured worker complained of ongoing right shoulder pain. The injured worker had completed five physical therapy sessions. The injured worker had been approved for a right shoulder injection. The injured worker reported that she had not filled prescriptions provided on her last office visit. The injured worker was working modified duty and trying to do her home exercise. Physical exam was remarkable for tenderness to palpation along the right shoulder joint line and the right trapezius muscles with functional range of motion of bilateral shoulders and neck and positive Hawkin's sign, Neer's sign and open can sign. Current diagnoses included right shoulder sprain/strain, right rotator cuff syndrome and cervical spine myofascial pain. The treatment plan included continuing physical therapy, scheduling a right shoulder injection, continuing home exercise and filling prescriptions provided on 3/20/15 (Voltaren Gel, Lidocaine ointment and Zanaflex).

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidocaine Ointment 5% day supply: 7 qty: 35.44 Refills 0: Upheld

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

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

Decision rationale: The requested Lidocaine Ointment 5% day supply: 7 qty: 35.44 Refills 0 is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Lidoderm, Pages 56-57, note that "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 or Lyrica)." It is not considered first-line therapy and only FDA approved for post-herpetic neuralgia. The injured worker has ongoing right shoulder pain. The treating physician has documented tenderness to palpation along the right shoulder joint line and the right trapezius muscles with functional range of motion of bilateral shoulders and neck and positive Hawkin's sign, Neer's sign and open can sign. The treating physician has not documented neuropathic pain symptoms, physical exam findings indicative of radiculopathy, failed first-line therapy or documented objective evidence of functional improvement from the previous use of this topical agent. The criteria noted above not having been met, Lidocaine Ointment 5% day supply: 7 qty: 35.44 Refills 0 is not medically necessary.

Voltaren Gel 1% day supply: 7 qty: 100 Refills: 0: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Non-steroidal anti-inflammatory agents, Page 111-112; Non-steroidal anti-inflammatory medications, GI symptoms and cardiovascular risk, Page 68-69 Page(s): 111-112, 68-69.

Decision rationale: The requested Voltaren Gel 1% day supply: 7 qty: 100 Refills: 0 is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Topical Analgesics, Non-steroidal anti-inflammatory agents, Page 111-112, recommend topical analgesics with documented osteoarthritis with intolerance to oral anti-inflammatory agents; Non-steroidal anti-inflammatory medications, GI symptoms and cardiovascular risk, Page 68-69, note that all NSAID s have the potential to raise blood pressure in susceptible patients. The injured worker has ongoing right shoulder pain. The treating physician has documented tenderness to palpation along the right shoulder joint line and the right trapezius muscles with functional range of motion of bilateral shoulders and neck and positive Hawkin's sign, Neer's sign and open can sign. The treating physician has not documented the patient's intolerance of these or similar medications to be taken on an oral basis, nor objective evidence of functional improvement from any previous use. The criteria noted above not having been met, Voltaren Gel 1% day supply: 7 qty: 100 Refills: 0 is not medically necessary.

