

Case Number:	CM15-0175563		
Date Assigned:	09/16/2015	Date of Injury:	07/25/2014
Decision Date:	11/09/2015	UR Denial Date:	08/26/2015
Priority:	Standard	Application Received:	09/08/2015

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: New York

Certification(s)/Specialty: Internal 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:

The injured worker is a 50 year old male who sustained an industrial injury July 25, 2014. Past medical history included asthma, depression, hypertension, sleep apnea, and stomach ulcers. Diagnoses are cervical facet joint pain; low back strain; degenerative joint disease of the shoulder region; degeneration of cervical and lumbar intervertebral disc; myofascial pain; impingement syndrome of the shoulder region, left; chronic pain. According to a physician's follow-up note dated August 13, 2015, the injured worker presented with constant bilateral neck pain with left upper extremity weakness and numbness noted in the left upper arm. He also reported constant bilateral low back pain and left shoulder pain with radiation to the left upper arm pain. He has completed 8 sessions of physical therapy with less pronounced tingling in the left upper extremity and the neck and shoulder pain is infrequent. He reported greater activity tolerance at work. An opioid contract is on file and a urine drug screen was within normal limits as of April 14, 2015. He presently is taking Norco with a 50% decrease in pain and no adverse effects. Physical examination revealed; gait is normal; tenderness and spasm over the paraspinal muscles and facet joints on both sides and muscle spasm over the trapezius muscle both sides, range of motion normal, Lhermitte's sign positive; both upper extremities- Hawkins and Kennedy tests are positive on the left side. At issue, is the request for authorization for Lidocaine, Hydrocodone-Acetaminophen, Cyclobenzaprine, and Gabapentin. The treating physician documented on August 13, 2015, results of an MRI of the left shoulder dated May 27, 2015 as; at least low grade intrasubstance tearing of the anterior and mid fibers of the left supraspinatus tendons footprint. No high-grade partial thickness or full thickness rotator cuff

tear of the left shoulder; intact labrum of the left shoulder; moderate osteoarthritis of the left AC joint. The treating physician documented on August 13, 2015, results of an MRI of the cervical spine dated May 27, 2015 as; mild canal stenosis at C5-6 secondary to 3mm central protrusion; moderate right, mild left neural foraminal narrowing at C5-6 secondary to facet degenerative disease uncovertebral hypertrophy; mild canal stenosis at C6-7, secondary to a 3.5mm central and left paracentral disc protrusion; mild bilateral neural foraminal narrowing at C6-7 secondary to facet degenerative disease and uncovertebral hypertrophy; additional levels of degenerative disc and facet disease; this refers to moderate bilateral facet degenerative disease at C4-5 in addition to mild bilateral facet degenerative disease at C3-4 and mild right facet degenerative disease at C2-3. According to utilization review dated August 26, 2015 the request for Lidocaine 5% (700 mg-patches) #30 x 2 refills is non-certified. The request for Hydrocodone-Acetaminophen 10-325mg one (1) every 12 hours #30. The request for Cyclobenzaprine 5mg one (1) QD #30 x 2 refills is non-certified. The request for Gabapentin 300mg one (1) QD #30 is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidocaine 5% (700 mg/patch) #30 times 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy, including tri-cyclic or SNRI anti-depressants or an anti-epileptic drug. Per guidelines, further research is needed to recommend Lidoderm for the treatment of chronic neuropathic pain disorders other than post-herpetic neuralgia. Physician reports fail to demonstrate supporting evidence of significant objective improvement in the injured worker's pain to establish the medical necessity for ongoing use of Lidoderm patch. The request for Lidocaine 5% (700 mg/patch) #30 times 2 refills is not medically necessary by lack of meeting MTUS criteria.

Hydrocodone/Acetaminophen 10/325 mg one every 12 hrs #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: MTUS recommends that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects must be documented with the use of Opioids. Satisfactory response to treatment may be indicated by the patient's decreased pain,

increased level of function, or improved quality of life. Guidelines recommend using key factors such as pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors, to monitor chronic pain patients on opioids. Assessment for the likelihood that the patient could be weaned from opioids is recommended if there is no overall improvement in pain or function, unless there are extenuating circumstances and if there is continuing pain with the evidence of intolerable adverse effects. The injured worker complains of chronic neck, low back and left shoulder pain. Although there is report of some improvement, documentation fails to demonstrate adequate objective improvement in level of function or pain, to support the medical necessity for continued use of opioids. In the absence of significant response to treatment, the request for Hydrocodone/Acetaminophen 10/325 mg one every 12 hrs #30 is not medically necessary.

Cyclobenzaprine 5 mg 1 once a day #30 times 2: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: Cyclobenzaprine (Flexeril) is a skeletal muscle relaxant and a central nervous system depressant recommended as a treatment option to decrease muscle spasm in conditions such as low back pain. Per MTUS guidelines, muscle relaxants are recommended for use with caution as a second-line option for only short-term treatment of acute exacerbations in patients with chronic low back pain. The greatest effect appears to be in the first 4 days of treatment and appears to diminish over time. Documentation fails to indicate acute exacerbation or significant objective improvement in the injured worker's pain or functional status to justify continued use of cyclobenzaprine. The request for Cyclobenzaprine 5 mg 1 once a day #30 times 2 is not medically necessary per MTUS guidelines.

Gabapentin 300 mg 1 once a day #3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Anti-epilepsy drugs (AEDs).

Decision rationale: MTUS states that Anti-epilepsy drugs (AEDs) are recommended for neuropathic pain (pain due to nerve damage). After initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. The injured worker complains of chronic neck, low back and left shoulder pain. Documentation fails to show significant objective improvement in pain or level of function to support the medical necessity for continued use of Gabapentin. The request for Gabapentin 300 mg 1 once a day #3 is not medically necessary by MTUS