

Case Number:	CM15-0096500		
Date Assigned:	05/26/2015	Date of Injury:	12/08/2003
Decision Date:	07/07/2015	UR Denial Date:	05/06/2015
Priority:	Standard	Application Received:	05/19/2015

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: Florida

Certification(s)/Specialty: Family Practice

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 51 year old, male who sustained a work related injury on 12/8/03. The diagnoses have included disorder of the bursae and tendons in shoulder region, bicipital tenosynovitis, localized osteoarthritis in shoulder region, medial and lateral epicondylitis of elbow, elbow contusion and hand strain/sprain. Treatments have included oral medications, Voltaren gel, Lidoderm patches and physical therapy with good pain relief. In the PR-2 dated 4/27/15, the injured worker complains of right shoulder pain that radiates down arm to right hand. He describes the pain as constant and dull. He states he feels numbness and tingling in his right hand. He rates his pain level a 2/10 with medications and a 6/10 without medications. Upon examination, he has mild tenderness to palpation of right acromioclavicular joint. He has improved right shoulder range of motion abduction and flexion greater than 90 degrees. The treatment plan includes a continuation with refills of medications and a request for more physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50mg quantity 180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 93-94; 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-80 of 127.

Decision rationale: In accordance with California MTUS guidelines, narcotics for chronic pain management should be continued if: "(a) If the patient has returned to work; (b) If the patient has improved functioning and pain." MTUS guidelines also recommend that narcotic medications only be prescribed for chronic pain when there is evidence of a pain management contract being upheld with proof of frequent urine drug screens. Regarding this patient's case, there is no objective evidence of functional improvement. Likewise, this requested chronic narcotic pain medication is not considered medically necessary.

Norco 10/325mg quantity 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-80 of 127.

Decision rationale: In accordance with California MTUS guidelines, narcotics for chronic pain management should be continued if: "(a) If the patient has returned to work; (b) If the patient has improved functioning and pain." MTUS guidelines also recommend that narcotic medications only be prescribed for chronic pain when there is evidence of a pain management contract being upheld with proof of frequent urine drug screens. Regarding this patient's case, there is no objective evidence of functional improvement. Likewise, this requested chronic narcotic pain medication is not considered medically necessary.

Voltaren Gel 1% quantity 1: 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 NSAIDS Page(s): 64, 102-105, 66.

Decision rationale: In accordance with California MTUS guidelines, NSAIDS are recommended as an option for short-term symptomatic relief. These guidelines state, "A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics." The MTUS guidelines do not recommend chronic use of NSAIDS due to the potential for adverse side effects. Likewise, this request for Voltaren Gel is not medically necessary.

Lidoderm Patches quantity 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine patch); Topical Analgesics Page(s): 56-57; 112.

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

Decision rationale: In accordance with California Chronic Pain MTUS guidelines, Lidoderm (topical Lidocaine) may be recommended for localized peripheral pain after there has been a trial of a first-line treatment. The MTUS guideline specifies "tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica" as first line treatments. The provided documentation does not show that this patient was tried and failed on any of these recommended first line treatments. Topical Lidoderm is not considered a first line treatment and is currently only FDA approved for the treatment of post-herpetic neuralgia. Likewise, for the aforementioned reasons, the requested Lidoderm Patches are not medically necessary.

Physical therapy quantity 12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99 of 127.

Decision rationale: In accordance with MTUS guidelines, the physical medicine recommendations state, "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." Guidelines also state, "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." This patient has previously had physical therapy, but now his physician is requesting an additional 12 sessions. The guidelines recommend fading of treatment frequency with transition to a home exercise program, which this request for a new physical therapy plan does not demonstrate. Furthermore, there are no documented objective benefits that have been derived from the physical therapy sessions that he has already received. Likewise, this request is not medically necessary.