

<b>Case Number:</b>	CM14-0155432		
<b>Date Assigned:</b>	09/25/2014	<b>Date of Injury:</b>	07/13/2001
<b>Decision Date:</b>	12/18/2014	<b>UR Denial Date:</b>	09/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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:

The patient is a 66 year old male with an injury date of 07/13/01. Based on the 07/02/14 progress report provided by treating physician, the patient complains of pain to the neck, left shoulder and low back pain that radiates to his bilateral extremities. Physical examination to the cervical and lumbar spines revealed tenderness to palpation and spasm to the paravertebral muscles. Range of motion was decreased in all planes of the cervical and lumbar spines. Patient has been given intramuscular injection of Celestone to the left shoulder per treater report dated 07/02/14. Physical therapy notes from 09/13/13 - 11/06/13 reported 7 of 8 visits. Neurontin, Soma and Percocet have been prescribed in progress reports dated 09/13/13 and 07/02/14. Treater has quoted ACOEM guidelines with requests. Voltaren gel was prescribed on 07/02/14 for joint pain. Patient is permanent and stationary. Diagnosis 07/02/14- cervical spine disc bulge- left shoulder, possible rotator cuff tear, history of rotator cuff tear- lumbar spine, multilevel disc bulge with left sided S1 radiculopathy. The utilization review determination being challenged is dated 09/09/14. Treatment reports were provided from 09/13/13 - 08/04/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Neurontin 600mg, #60, DOS 07/02/14: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 18, 19.

**Decision rationale:** The patient complains of pain to the neck, left shoulder and low back pain that radiates to his bilateral extremities. The request is for Neurontin 600mg, #60, DOS 07/02/14. Patient's diagnosis dated 07/02/14 included cervical spine disc bulge, left shoulder, possible rotator cuff tear, history of rotator cuff tear and lumbar spine, multilevel disc bulge with left sided S1 radiculopathy. Physical therapy notes from 09/13/13 - 11/06/13 reported 7 of 8 visits. Patient is permanent and stationary. MTUS has the following regarding Gabapentin on pg 18, 19: "Gabapentin (Neurontin, Gabarone, generic available) has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain." Treater has quoted ACOEM guidelines as reference with the request, without discussing the request. Neurontin has been prescribed in progress reports dated 09/13/13 and 07/02/14. The treater does not discuss efficacy. There is no discussion as to how this medication has been helpful with pain and function. MTUS page 60 require recording of pain and function when medications are used for chronic pain. Request does not meet MTUS indications therefore the request is not medically necessary.

**Soma 350mg, #120 DOS 07/02/14: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

**Decision rationale:** The patient complains of pain to the neck, left shoulder and low back pain that radiates to his bilateral extremities. The request is for Soma 350mg, #120 DOS 07/02/14. Patient's diagnosis dated 07/02/14 included cervical spine disc bulge, left shoulder, possible rotator cuff tear, history of rotator cuff tear and lumbar spine, multilevel disc bulge with left sided S1 radiculopathy. Physical therapy notes from 09/13/13 - 11/06/13 reported 7 of 8 visits. Neurontin, Soma and Percocet have been prescribed in progress reports dated 09/13/13 and 07/02/14. Patient is permanent and stationary. MTUS, Chronic Pain Medication Guidelines, Muscle Relaxants, page 63-66: "Carisoprodol (Soma, Soprodal 350, Vanadom, generic available): Neither of these formulations is recommended for longer than a 2 to 3 week period." Abuse has been noted for sedative and relaxant effects. Treater has quoted ACOEM guidelines as reference with the request, without discussing the request. Soma has been prescribed in progress reports dated 09/13/13 and 07/02/14, which is more than 2 months from the UR date of 09/09/14. MTUS recommends Soma only for a short period. The request is not medically necessary.

**Percocet 10/325mg, #60, DOS 07/02/14: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines criteria for use of opioids Page(s): 88, 89, 78.

**Decision rationale:** The patient complains of pain to the neck, left shoulder and low back pain that radiates to his bilateral extremities. The request is for Percocet 10/325mg, #60, DOS 07/02/14. Patient's diagnosis dated 07/02/14 included cervical spine disc bulge, left shoulder, possible rotator cuff tear, history of rotator cuff tear and lumbar spine, multilevel disc bulge with left sided S1 radiculopathy. Physical therapy notes from 09/13/13 - 11/06/13 reported 7 of 8 visits. Neurontin, Soma and Percocet have been prescribed in progress reports dated 09/13/13 and 07/02/14. Patient is permanent and stationary. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Treater has quoted ACOEM guidelines as reference with the request, without discussing the request. Percocet has been prescribed in progress reports dated 09/13/13 and 07/02/14. In this case, treater has not stated how Percocet reduces pain and significantly improves patient's activities of daily living; the four A's are not specifically addressed including discussions regarding adverse effects, aberrant drug behavior and specific ADL's, etc. Given the lack of documentation as required by MTUS, the request is not medically necessary.

**Voltaren gel 100g, #3 DOS 07/02/14:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The patient complains of pain to the neck, left shoulder and low back pain that radiates to his bilateral extremities. The request is for Voltaren gel 100g, #3 DOS 07/02/14. Patient's diagnosis dated 07/02/14 included cervical spine disc bulge, left shoulder, possible rotator cuff tear, history of rotator cuff tear and lumbar spine, multilevel disc bulge with left sided S1 radiculopathy. Physical therapy notes from 09/13/13 - 11/06/13 reported 7 of 8 visits. Neurontin, Soma and Percocet have been prescribed in progress reports dated 09/13/13 and 07/02/14. The MTUS has the following regarding topical creams (p111, chronic pain section): Topical Analgesics: "Recommended as an option as indicated below. Non-steroidal anti-inflammatory agents (NSAIDs): ... FDA-approved agents: Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis for pain in joints that lends themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist)." It is also recommended for tendinitis of peripheral joints. Voltaren gel was prescribed on 07/02/14 for joint pain. Treater has not indicated which joint the gel would be applied to. Patient does not have peripheral joint tendinitis or osteoarthritis. The request does not meet guideline indications. The request is not medically necessary.

