

Case Number:	CM14-0029182		
Date Assigned:	06/20/2014	Date of Injury:	10/26/2012
Decision Date:	08/19/2014	UR Denial Date:	02/14/2014
Priority:	Standard	Application Received:	03/07/2014

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 & Rehabilitation, 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 injured worker is a 49-year-old female who date of injury was reported 10/26/2012. The mechanism of injury was not provided within the medical records. The clinical note dated 02/11/2014 indicated diagnoses of degeneration of lumbosacral intervertebral disc, degeneration of cervical intervertebral disc, knee pain, and degeneration of intervertebral disc. The injured worker reported bilateral neck pain and low back pain that radiated to both extremities, left greater than right, in all fingers. Pain in the back radiated to the bilateral lower extremities, left greater than right, with radiation to the right hip. The injured worker described the pain as sharp. She rated the pain 8/10, constant in intensity. The injured worker had upper extremity weakness bilaterally and lower extremity weakness bilaterally, numbness in the upper extremities, tingling in the upper extremities. The injured worker reported stiffness in the neck and interference with sleep. The injured worker reported she felt depressed and anxious. The injured worker reported numbness/tingling in the bilateral hands, numbness/tingling in bilateral legs from the back, lateral calf left greater than right. The injured worker reported the pointer fingers were very stiff and hard to bend bilaterally. She reported factors that aggravated her pain were carrying, lifting, walking down stairs, and alleviating factors were heat and rest. The injured worker's prior treatments included diagnostic imaging and medication management. The injured worker's medication regimen included Voltaren, Gabapentin, and Thermacare heat wraps. The provider submitted requests For Gabapentin, Voltaren, and Thermacare heat wraps. A request for authorization was not submitted for review to include the date the treatment was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 100 mg capsule: # 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 16-17. Decision based on Non-MTUS Citation FDA, Neurontin.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SPECIFIC ANTI-EPILEPSY DRUGS, page 18 Page(s): 18.

Decision rationale: The request for Gabapentin 100 mg capsule: # 90 is not medically necessary and appropriate. The California MTUS guidelines recognize Gabapentin/Neurontin 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. There is lack of documentation of efficacy and functional improvement with the use of this medication. In addition, it was not indicated how long the injured worker had utilized this medication. Moreover, the request did not indicate a frequency for this medication. Therefore, the request is not medically necessary.

Voltaren 1% topical - 1100 gm tube refills: 1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel, page 111 Page(s): 111.

Decision rationale: The request for Voltaren 1% topical - 1100 gm. tube refills x1 is not medically necessary. California MTUS states Voltaren Gel 1% (Diclofenac) is an FDA-approved agent indicated for relief of osteoarthritis pain in joints that lends themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). There is lack of documentation of efficacy and functional improvement with the use of this medication. In addition, it was not indicated how long the injured worker had been utilizing this medication. Moreover, the request does not indicate a frequency for this medication. Therefore, the request is not medically necessary and appropriate.

Thermacare neck/wrist/shoulder bandage: 30 bandage(s) refills: 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, Pain chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Thermotherapy.

Decision rationale: The request for Thermacare neck/wrist/shoulder bandage: 30 bandage(s) refills: 2 is not medically necessary. The Official Disability Guidelines state Thermacare/Thermotherapy is still under study. For several physical therapy interventions and indications (e.g., thermotherapy using heat, therapeutic exercise, massage, electrical stimulation, mechanical traction), there was a lack of evidence regarding efficacy. In addition, there is lack of documentation of efficacy and functional improvement with the use of this medication. The provider did not indicate a rationale for the request. Moreover, the request does not indicate a frequency for this medication. Therefore, the request is not medically necessary and appropriate.