

Case Number:	CM14-0188029		
Date Assigned:	11/18/2014	Date of Injury:	11/24/1998
Decision Date:	01/06/2015	UR Denial Date:	11/05/2014
Priority:	Standard	Application Received:	11/11/2014

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 Anesthesiology and is licensed to practice in Tennessee, North Carolina & Georgia. 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 61-year-old female who reported an injury on 11/24/1998. The mechanism of injury was not provided. Diagnoses included GERD/dyspepsia with gastroparesis, post traumatic left lower extremity neuropathy, fibromyalgia, cervical spine disease with foraminal stenosis, mid/low back pain/strains, chronic pancreatitis, bilateral TMJ dysfunction, mixed headaches, dyslipidemia, depression with anxiety, constipation, xerostomia, urinary incontinence, fecal incontinence, insomnia, excessive daytime sleepiness/fatigue, and irritable bowel syndrome (IBS). Past treatments included medications. In the clinical note dated 08/26/2014, the injured worker complained of increased pain levels. Physical examination indicated no nystagmus, no JVD, no clubbing, and no cyanosis. Current medications included Cymbalta, Ativan, Nuvigil, Atenolol, Savella, Nexium, Flector patches, Voltaren gel, and Fiorinal. The rationale for the request was not provided for Voltaren gel. However, for Fiorinal, it was for headaches. The Request for Authorization Form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren gel 1%, 25 day supply, quantity 100 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical anaglesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The request for Voltaren gel 1%, 25 day supply #100 with 1 refill is not medically necessary. The California MTUS Guidelines recommend topical analgesics for short term use of 4 to 12 weeks. The guidelines primarily recommend topical analgesics for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Voltaren gel is indicated for relief of osteoarthritis pain in joints that lend themselves to treatment like the ankle, elbow, foot, hand, knee, and wrist. Voltaren gel has not been evaluated for treatment of the spine, hip, or shoulder. The medical records indicate the patient has been prescribed Voltaren gel 1% since at least 04/30/2014, which exceeds the guidelines' recommended limit of 12 weeks. Additionally, the medical records lack documentation of the efficacy of the medication, the timeframe of efficacy, the efficacy of functional status that the medication provides, and pain rating pre and post medication. The request does not indicate the frequency, dosage, or application site of the medication. As such, the request for Voltaren gel 1%, 25 day supply#100 with 1 refill is not medically necessary.

Bupropion /Aspirin/Caffeine/ Codeine capsule 30mg, 30 day supply, quantity 120: 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 BCAs Page(s): 23.

Decision rationale: The request for Bupropion /Aspirin/Caffeine/ Codeine capsule 30mg, 30 day supply, quantity 120 is not medically necessary. The California MTUS Guidelines do not recommend barbiturate containing agents for chronic pain. The potential for drug dependence is high, and there is no evidence of analgesic efficacy due to the barbiturate contents. There is a risk of medication overuse, as well as rebound headache. The medical records lack documentation of the efficacy of the medication, the time frame of efficacy, the efficacy of functional status the medication provides, and the pain rating pre and post medication. Additionally, the request does not indicate the frequency of the medication. As such, the request for Bupropion /Aspirin/Caffeine/ Codeine capsule 30mg, 30 day supply, quantity 120 is not medically necessary.