

Case Number:	CM14-0210533		
Date Assigned:	12/23/2014	Date of Injury:	09/19/1994
Decision Date:	12/14/2015	UR Denial Date:	11/20/2014
Priority:	Standard	Application Received:	12/15/2014

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. 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: Arizona, California
 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 53 year old male, who sustained an industrial injury on 9-19-1994. The injured worker was diagnosed as having sacroiliac joint dysfunction, thoracic spondylosis without myelopathy, facet arthropathy-left upper thoracic, lumbar radiculopathy, lumbar degenerative disc disease, and cervical myofascial syndrome. Treatment to date has included diagnostics, thoracic epidural steroid injection, and medications. On 7-25-2014, the injured worker complains of bilateral buttock pain, severe midthoracic area pain, and low back pain with radiation to the bilateral lower extremities. Pain was rated 5 out of 10 on a good day (noting that previous pain rating was 4 on a good day). Pain was described as sharp, throbbing, pins and needles, numbness, electrical-shooting, cramping, weakness, and spasm. Aggravating factors were cold, activity, sitting, standing, and walking. Alleviating factors were heat, rest, lying down, medication, and massage. A review of symptoms was positive for change in bowel habits, tinnitus, abnormal bruising, depression and anxiety. Exam of the cervical spine noted diffuse tenderness on the lower lumbar facet joint and upper extremities. Exam of the thoracic spine noted severe tenderness over the upper parathoracic area, moderate bilateral parathoracic spasm, and limited range of motion. Sensation was decreased in the T6 dermatome. Exam of the lumbar spine noted diffuse tenderness in the lower back, mild tenderness over the bilateral sacroiliac joints, limited range of motion, positive straight leg raise bilaterally, left lumbar spasm, and weakness in both lower extremities. He was prescribed Voltaren gel 1%, Cyclobenzaprine, Percocet 10-325mg, Oxycontin 20mg, and Lyrica. Urine toxicology (4-25- 2014) was positive for opiates and oxycodone, consistent with compliance. The duration of medication use could

not be determined. On 11-20-2014 Utilization Review non-certified a request for Percocet 10-325mg #120 with 3 refills (one month supply approved for weaning recommendations), Oxycontin 20mg #90 with 3 refills (one month supply approved for weaning recommendations), and Voltaren gel 1% 480gm with 3 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg, #120 x 3 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): Opioids for chronic pain, Opioids for neuropathic pain.

Decision rationale: Percocet is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated as 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant had been on Percocet for an unknown length of time along with Oxycontin. There was no mention of Tylenol, NSAID, Tricyclic or weaning failure. Future need and response cannot be predicted. The continued use of Percocet with 3 refills is not medically necessary.

Oxycontin 20mg #90 x 3 refill: 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, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain.

Decision rationale: According to the MTUS guidelines, opioids are not indicated as 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant had been on Oxycontin along with Percocet for an unknown length of time. There was no mention of Tylenol, NSAID, Tricyclic or weaning failure. Future need cannot be predicted. Long-term use has not been studied. The continued use of Oxycontin with 3 refills is not medically necessary.

Voltaren gel 1%, #480gm x 3 refill: 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: According to the MTUS guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety, primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Voltaren gel is a topical analgesic. It is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. It is recommended for short-term use (4-12 weeks) for arthritis. In this case, the claimant had been on the gel for several months and additional 3 months refill is not indicated. Topical NSAIDS can reach systemic levels similar to oral NSAIDS increasing the risk of GI and renal disease. There are diminishing effects after 2 weeks. The Voltaren gel is not medically necessary.