

Case Number:	CM15-0000892		
Date Assigned:	01/12/2015	Date of Injury:	03/21/2012
Decision Date:	03/12/2015	UR Denial Date:	12/05/2014
Priority:	Standard	Application Received:	01/05/2015

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: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 male, who sustained an industrial injury on 3/21/2012 when a fountain crushed his left middle finger. The injured worker has underwent two surgeries on 4/3/12 and 5/15/12 and has had persistent difficulty and dysfunction in the left middle finger and left shoulder and neck pain due to the weight of the fountain. Primary Treating Physician's Progress Report for 11/5/2014 noted the injured worker has a history of bilateral carpal tunnel syndrome, left shoulder discomfort and neck pain. The injured worker receives periodic injections for his upper extremities pain. He continues to use Transcutaneous Electrical Nerve Stimulation (TENS) unit and finds it very helpful. The injured worker had complaints of left long finger pain, dysfunction and numbness; left shoulder pain; neck pain; constipation and gastroesophageal complaints and anxiety, depression and insomnia due to chronic pain. The documentation noted that on 8/27/12 a Magnetic Resonance Imaging (MRI) of the cervical spine was completed and an MRI of the left shoulder without contrast was done. On 9/18/12 an electromyogram/NCV was done. The injured worker had a MRI on 3/18/2014 of the cervical spine with an impression of abnormality in the spinal cord from approximately C3 level to C7-T1 level. The injured worker was with diagnosis of left middle finger distal phalanx fracture with residual dysfunction and los of motion and swelling; left shoulder pain with partial tear of rotator cuff per Magnetic Resonance Imaging; cervical strain with radicular symptoms to the left, rule out herniated disc; electrodiagnostic study of 9/18/12 evidence of bilateral carpal tunnel syndrome and left-sided cubital tunnel syndrome and secondary depression, anxiety and depression due to the above diagnosis. The documentation noted that the injured worker is not a

permanent and stationary/MMI and should reach that status in the next six to nine months if there are no complications. There were three utilization review reviews performed on 12/5/2014, the requested diclofenac sodium 1.5% #150 was modified to diclofenac 1.0% gel #150gms with 1 refill with the MTUS Chronic Pain Medical Treatment Guidelines used. The requested zofran 4mg has been non-certified with the CA MTUS and ODG used. The requested pennsaid 1/3% has been non-certified with the ODG used.

IMR ISSUES, DECISIONS AND RATIONALES

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

MEDICATION: DICLOFENAC SODIUM 1.5% #150: 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 section Page(s): 111-113.

Decision rationale: Per the MTUS Guidelines, the use of topical analgesics is recommended as an option for some agents. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. Voltaren Gel 1% is FDA approved and 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. 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). Utilization review recommended 1% diclofenac over the requested 1.5% diclofenac. The request for diclofenac sodium 1.5% is not consistent with the recommendations of the MTUS Guidelines. The request for DICLOFENAC SODIUM 1.5% #150 is determined to not be medically necessary.

MEDICATION: ZOFRAN 4MG: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain chapter, Antiemetics (for opioid nausea)

Decision rationale: The MTUS Guidelines do not address the use of ondansetron. The ODG does not recommend the use of antiemetics for nausea and vomiting secondary to chronic opioid use. Ondansetron is FDA approved for use with nausea as a result of chemotherapy or radiation treatments, post-operative nausea, and acutely in gastroenteritis. The injured worker does not meet the criteria for Zofran as recommended by the ODG. The request for ZOFRAN 4MG is determined to not be medically necessary.

MEDICATION: PENNSAID 1.3%: 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 section Page(s): 111-113. Decision based on Non-MTUS Citation X Official Disability Guidelines (ODG), Pain Chapter, Pennsaid¹/₂ (diclofenac sodium topical solution)

Decision rationale: Per the MTUS Guidelines, the use of topical analgesics is recommended as an option for some agents. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. Per the ODG, Pennsaid is not recommended as a first-line treatment. Topical diclofenac is recommended for osteoarthritis after failure of an oral NSAID or contraindications to oral NSAIDs, and after considering the increased risk profile with diclofenac, including topical formulations. In studies Pennsaid was as effective as oral diclofenac, but was much better tolerated. FDA approved Pennsaid Topical Solution in 2009 for the treatment of the signs and symptoms of osteoarthritis of the knee, and the FDA requires a Risk Evaluation and Mitigation Strategy (REMS) from the manufacturer to ensure that the benefits of this drug outweigh its risks. The requesting physician has also requested for topical diclofenac 1.5% which was modified to topical diclofenac 1%. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines and the ODG. The request for PENNSAID 1.3% is determined to not be medically necessary.