

Case Number:	CM15-0006739		
Date Assigned:	02/06/2015	Date of Injury:	05/07/1996
Decision Date:	03/30/2015	UR Denial Date:	12/16/2014
Priority:	Standard	Application Received:	01/12/2015

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: Florida
 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 67 year old female, who sustained an industrial injury on 5/7/96. She has reported pain in the neck and shoulders. The diagnoses have included left shoulder impingement, C5-C6 disk bulge and partial left rotator cuff tear. Treatment to date has included MRI of the left shoulder, joint injections, electrodiagnostic studies and oral medications. As of the PR2 dated 11/13/14, the injured worker reported shooting pain in the upper extremities. The treating physician requested Neurontin 600mg #180, a neck traction with air bladder, Voltaren gel, left shoulder arthroscopic evaluation, pre-operative clearance labs (CBC, CMP, H&P, EKG and chest x-ray), 21 day rental of polar care, 1 shoulder immobilizer, Augmentin 875mg/125mg and Zofran 8mg. On 12/16/14 Utilization Review non-certified a request for Neurontin 600mg #180, a neck traction unit with air bladder and Voltaren gel and certified Celebrex 200mg #30 and a neck pillow. The left shoulder arthroscopic evaluation, pre-operative clearance labs (CBC, CMP, H&P, EKG and chest x-ray), 21 day rental of polar care, 1 shoulder immobilizer, Augmentin 875mg/125mg and Zofran 8mg were all conditionally non-certified pending further documentation. The utilization review physician cited the ACOEM guidelines chapter 8 and medical necessity. On 1/12/15, the injured worker submitted an application for IMR for review of Neurontin 600mg #180, a neck traction with air bladder, Voltaren gel, left shoulder arthroscopic evaluation, pre-operative clearance labs (CBC, CMP, H&P, EKG and chest x-ray), 21 day rental of polar care, 1 shoulder immobilizer, Augmentin 875mg/125mg and Zofran 8mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurontin 600mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs).

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

Decision rationale: Gabapentin (Neurontin) is recommended by MTUS guidelines for the treatment of Neuropathic pain. As the utilization review physician noted, the documentation provided does not show any definite evidence of this patient having Neuropathic pain. In fact, it is stated in an office that she has not had any numbness or tingling of significance. Likewise, this request for Neurontin is not considered medically necessary.

One neck traction unit with air bladder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173.

Decision rationale: According to ACOEM guidelines, as cited within MTUS guidelines, there is no high grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction. Regarding this patient's case, a neck traction device with air bladder has been requested for treatment of this patient's chronic neck pain. Since there is no high grade scientific evidence to support the use of traction devices, this request cannot be considered medically necessary.

One (1) prescription of Voltaren gel: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Voltaren Gel (diclofenac)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: In accordance with California MTUS guidelines, topical analgesics are considered Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Guidelines go on to state that, There is little to no research to support the use of many of these agents. The guideline specifically says, Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The requested

topical analgesic contains an NSAID, Voltaren. MTUS guidelines specifically state regarding Non-steroidal antiinflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. 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. Likewise, the requested medication is not medically necessary.