

Case Number:	CM15-0142371		
Date Assigned:	08/03/2015	Date of Injury:	10/07/2009
Decision Date:	08/31/2015	UR Denial Date:	06/22/2015
Priority:	Standard	Application Received:	07/22/2015

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 47 year old female, who sustained an industrial injury on 10-07-2009. She has reported injury to the neck and right shoulder. The diagnoses have included neck sprain-strain; cervical radiculopathy; rotator cuff syndrome; and chronic pain syndrome. Treatment to date has included medications, diagnostics, TENS (transcutaneous electrical nerve stimulation) unit, cognitive behavioral therapy, acupuncture, physical therapy, functional restoration program, and home exercise program. Medications have included Tylenol No. 3, Gralise, Cymbalta, Voltaren gel. A progress report from the treating physician, dated 06-03-2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of pain in the right shoulder and arm; the right upper extremity pain is described as tingling, achy, radiating, squeezing, numbing, and cramping; the severity of the pain is rated at 3-6 out of 10 on the pain scale; and modifying factors include medications, heat, and TENS unit. Objective findings included trigger points identified in the right superior trapezius with radiation up the neck; right shoulder range of motion is decreased and painful; and there is positive Tinel's noted at the right wrist. The treatment plan has included the request for Voltaren gel 1% quantity 3; Tylenol 3 quantity 30; and Gralise 300mg quantity 30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren gel 1% quantity 3: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Topical Analgesics (page 111), NONSELECTIVE NSAIDS, page(s) 107 Page(s): 111, 107.

Decision rationale: Voltaren Gel (Diclofenac) is a nonsteroidal anti-inflammatory drug (NSAID). According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. There is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Diclofenac is used for osteoarthritis. There is no evidence of osteoarthritis in this case. There is no clear evidence of efficacy of this medication with modest pain improvement (From 4/10 to 3/10) and no functional improvement. In addition there is no clear documentation of failure or intolerance of first line medications. Therefore request for Voltaren gel 1% quantity 3 is not medically necessary.

Tylenol 3 quantity 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids, page(s) 76-79.

Decision rationale: According to MTUS guidelines, Tylenol #3 (Tylenol with Codeine) as well as other short acting opioids are indicated for intermittent or breakthrough pain (page 75). It can be used in acute post operative pain. It is not recommended for chronic pain of long-term use as prescribed in this case. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules: "(a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily

living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework." There is no documentation of reduction of pain and functional improvement with previous use of Tylenol#3. There is a modest improvement of pain sensation from 4/10 to 3/10. There is no clear documentation of the efficacy/safety of previous use of Tylenol #3. There is no recent documentation of compliance of the patient with her medications. Therefore, the prescription of Tylenol 3 quantity 30 is not medically necessary.

Gralise 300mg quantity 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 49.

Decision rationale: According to MTUS guidelines, "Gabapentin is an anti-epilepsy drug (AEDs - also referred to as anti-convulsants), which 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 no documentation of neuropathic pain in this case. There are no controlled studies supporting the use of Gralise in chronic neck pain. Gralise is the extended release form of Neurontin. It usually used in case of intolerance to Neurontin. There is no documentation of intolerance to Neurontin in this case. There is no documentation of pain and functional improvement with previous use of Gralise. Therefore, the prescription of Gralise 300mg quantity 30 not medically necessary.