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| <b>Case Number:</b>   | CM15-0144757 |                              |            |
| <b>Date Assigned:</b> | 08/05/2015   | <b>Date of Injury:</b>       | 05/16/1986 |
| <b>Decision Date:</b> | 09/21/2015   | <b>UR Denial Date:</b>       | 07/09/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 07/27/2015 |

### 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: Pennsylvania

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 76 year old male, who sustained an industrial injury on 5-16-1986. Diagnoses include cervical spondylosis with associated cephalgia, lumbar and lumbosacral spondylosis with associated chronic pain syndrome, and upper thoracic muscle spasms and fibromyositis. Treatment to date has included chiropractic care and medications including Norco, MSM (methylsulfonylmethane), Glucosamine sulfate and Voltaren gel. Per the Primary Treating Physician's Progress Report dated 6-08-2015, the injured worker reported flare-up of symptoms related to his work injury. He has great difficulty performing any task that requires the turning of his head and neck. His lower back locks up in spasms 2-3 times per week. Physical examination revealed cervical spine rotation decreased 50% bilaterally with a great deal of pain on the left side. Sotohall was positive in the neck and bilateral leg lowering was positive in the lumbar spine. The plan of care included chiropractic care and physiotherapeutic modalities as part of a functional rehabilitation program as well as rest, stretching, exercises and heat and cold application. Authorization was requested for Glucosamine sulfate 500mg #90, MSM 500mg #30, Norco 10-325mg #120, and Voltaren gel 1% 100gm tube.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro DOS: 6.3.15 Glucosamine sulfate 500mg #90: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine Page(s): 50.

**Decision rationale:** According to the MTUS, glucosamine is recommended as an option in patients with moderate arthritis, especially for knee osteoarthritis. It has not been recommended for conditions such as spondylosis or fibromyositis. The record does not indicate that this worker does not have a diagnosis of osteoarthritis. Therefore, glucosamine is not medically necessary.

**Retro DOS: 6.3.15 MSM (methylsulfonylmethane) 500mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRPS, medications Page(s): 37.

**Decision rationale:** According to the MTUS, there is some evidence of efficacy for MSM for chronic regional pain syndrome. The MTUS does not give any other indications for MSM. There is no indication in the medical record that this worker has chronic regional pain syndrome for which MSM may be indicated. Therefore, the request is not medically necessary.

**Retro DOS: 6.3.15 Norco 10/325mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80-82. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

**Decision rationale:** According to the guidelines, determination for the use of opioids should not focus solely on pain severity but should include the evaluation of a wide range of outcomes including measures of functioning, appropriate medication use, and side effects. The guidelines state that measures of pain assessment that allow for evaluation of the efficacy of opioids and whether their use should be maintained include the following: 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 last. The criteria for long term use of opioids (6-months or more) includes among other items, documentation of pain at each visit and functional improvement compared to baseline using a numerical or validated instrument every 6 months. Opioids should be continued if the patient has returned to work and if there is improved functioning and pain. In this case the worker has not returned to work and there was no

documentation of any improvement in function other than a general statement that he has 50% functional improvement with activities of daily living with the medication versus not taking it. No specific objective comparisons to baseline function to substantiate a 50% functional improvement was provided. There was no description of the activities of daily living that were improved. The requested treatment is not medically necessary.

**Retro DOS: 6.3.15 Voltaren gel 1% 100g tube: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter.

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

**Decision rationale:** According to the MTUS, topical NSAIDs may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. Topical Diclofenac is indicated for the relief of osteoarthritis pain in joints that lend themselves to topical treatment which includes the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. Topical NSAIDs are not recommended for greater than 4-12 weeks. NSAIDs in general should be used secondary to acetaminophen for mild to moderate pain. The medical record in this case, does not indicate that this worker has any of the conditions for which a topical NSAID is indicated. According to the record, he has neck pain radiating to his left shoulder blade and down his lower back. There is no indication in the record that he has osteoarthritis pain of the ankle, elbow, foot, hand, knee or wrist. The request is not medically necessary.