

<b>Case Number:</b>	CM15-0208964		
<b>Date Assigned:</b>	10/27/2015	<b>Date of Injury:</b>	03/01/1999
<b>Decision Date:</b>	12/08/2015	<b>UR Denial Date:</b>	10/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/23/2015

### 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: 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 63-year-old female who sustained an industrial injury on 3-1-1999 and has been treated for failed neck surgery, chronic neck and low back pain, lumbar spondylosis and left carpal tunnel syndrome. On 9-24-2015 the injured worker reported neck and bilateral shoulder pain radiating down the spine to the sacral area. Pain was characterized as aching, numbness, cramping and stabbing, radiating through the right arm from the shoulder to the wrist. She was experiencing right wrist "symptoms"; and, right buttock stabbing and cramping radiating down the right leg, upper thigh, and foot. The physician stated that symptoms were the same as her last visit, with the addition of right wrist pain aggravated by fine hand movement. Pain intensity in her neck was reported to be 7-8 out of 10; arm pain 5-6 out of 10; and, back and leg pain 6-7 out of 10. Objective findings include limited cervical range of motion and tenderness over spinous processes and facet joints of the lower neck, and lumbar range of motion was noted to be intact but with pain. There was tenderness noted at the lumbosacral junction and over the paraspinal muscles. Documented treatment includes Voltaren gel helping with carpal tunnel pain for at least one month; OxyContin 30 mg three times per day; and, Oxycodone 30 mg 4 times per day as needed. Medical records show documentation of these two medications for at least one year. Medication is noted to provide "moderate to complete relief from pain," and the physician states she uses the minimal amount of analgesics "consistent with having a decent quality of life." Activities of daily living are stated to enhance her quality of life, no aberrant behaviors, "appropriate" urine drug screen 5-21-2015, "appropriate CURES report, and no adverse side effects. The treating physician's plan of care includes Oxycodone IR 30 mg #120 with no refills post-dated 10-22-2015 and 11-19-2015; Oxycontin 30 mg #90 with two refills post-dated 10-22-15 and 11-19-2015; and Voltaren Gel #100. Oxycodone and Oxycontin were both modified to #60, and Voltaren Gel was non-certified.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycontin 30 mg #90 with 2 Refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain, Opioids for neuropathic pain, Opioids, dosing.

**Decision rationale:** 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 Oxycontin along with Oxycodone. The combined dose exceeded the 120 mg of Morphine recommended for daily use. The claimant had been on the medications for over a year which also can potentially worsen risk of liver disease with the claimant's history of Hepatitis C. The continued use of Oxycontin as prescribed is unnecessary.

**Oxycodone IR 30 mg # 120 with 2 Refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain, Opioids for neuropathic pain, Opioids, dosing.

**Decision rationale:** 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 Oxycodone for a year without significant improvement in pain or function. There was no mention of Tylenol, NSAID, Tricyclic or weaning failure. In this case, the claimant had been on Oxycontin along with Oxycodone. The combined dose exceeded the 120 mg of Morphine recommended for daily use. In addition, the claimant had a history of Hepatitis C which can be worsened by using opioids. Future need cannot be determined. The continued use of Oxycodone with 2 refills is not medically necessary.

**Voltaren Gel #100:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**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 over a month. 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 continued use Voltaren gel is not medically necessary.