

Case Number:	CM15-0022680		
Date Assigned:	02/12/2015	Date of Injury:	03/07/2011
Decision Date:	03/31/2015	UR Denial Date:	01/08/2015
Priority:	Standard	Application Received:	02/06/2015

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 York
 Certification(s)/Specialty: Internal 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 59 year old female who sustained a work related injury March 7, 2011. According to a primary treating physician's progress report dated December 18, 2014, the injured worker presented for bilateral upper extremity pain, rated 5/10 with medications and 8/10 without and unchanged since the last visit. Diagnoses are documented as carpal tunnel syndrome and spasm muscle. Treatment included requests for medications and still awaiting possible surgery (digits on her left hand). She previously underwent surgical correction to the right DIP (distal interphalangeal joint) which she reports worked well. Work status is documented as permanent and stationary, retired. According to utilization review dated January 8, 2015, the request for Voltaren 1% gel QTY: 3 is non-certified, citing MTUS Chronic Pain Medical Treatment Guidelines. The request for Naproxen 500mg QTY: 60 is non-certified, citing MTUS Chronic Pain Medical Treatment Guidelines. The request for Pennsaid 1.5% solution QTY: 1 is non-certified, citing MTUS Chronic Pain Medical Treatment Guidelines. The request for Gralise ER 600mg QTY: 60 is non-certified, citing MTUS Chronic Pain Medical Treatment Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 1% gel, 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 Topical Analgesics Page(s): 111-113.

Decision rationale: Per CA MTUS, Voltaren gel 1% is a FDA-approved agent 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). The most common adverse reactions were dermatitis and pruritus. In this case the claimant has been certified for an oral nonsteroidal anti-inflammatory medication, Naprosyn. There is no indication for both oral and topical NSAIDs for the treatment of chronic musculoskeletal pain. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

Pennsaid 1.5% solution, quantity: 1: Upheld

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

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

Decision rationale: There is no indication for Voltaren gel. There is no indication for Pennsaid 1.5% solution. In this case the claimant has been certified for an oral nonsteroidal anti-inflammatory medication, Naprosyn. There is no indication for both oral and topical NSAIDs for the treatment of chronic musculoskeletal pain. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

Naproxen 500mg, quantity: 60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (Non-Steroidal Anti-Inflammatory Drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS- NSAIDs for treatment of chronic pain Page(s): 67.

Decision rationale: The requested medication, Naprosyn is medically necessary for the treatment of the claimant's pain condition. Naprosyn is a non-steroidal anti-inflammatory medication (NSAID). These medications are recommended for the treatment of chronic pain as a second line therapy after acetaminophen. The documentation indicates the claimant has significant bilateral upper extremity and the medication has proved beneficial for pain control. Medical necessity for the requested item has been established. The requested treatment is medically necessary.

Gralise ER 600mg, quantity: 60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS Page(s): 13.

Decision rationale: The recommended medication, Gralise ER is medically necessary for the treatment of the patient's condition. Per the documentation there is evidence that the claimant has neuropathic pain. Per California MTUS Guidelines 2009 antiepilepsy medications are a first line treatment for neuropathic pain. A recommended trial period for an adequate trial of Gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. The patient has been prescribed the medication and there is documentation of a positive response to this medical therapy. Medical necessity has been documented and the requested treatment is medically necessary for treatment of the patient's chronic pain condition.