

Case Number:	CM15-0051305		
Date Assigned:	03/24/2015	Date of Injury:	07/31/2013
Decision Date:	05/13/2015	UR Denial Date:	02/26/2015
Priority:	Standard	Application Received:	03/18/2015

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: California, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 58year old female, who sustained an industrial injury on 07/31/2013. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having cervical spine strain/sprain with spondylosis, thoracic to lumbar sprain/strain with bilateral lower extremity radiculopathy along with multi-level disc protrusion/stenosis, left shoulder sprain/strain, sleep loss, stress, and headaches. Treatment to date has included medication regimen, home exercise program, electromyogram with nerve conduction velocity, and magnetic resonance imaging. In a progress note dated 02/06/2015 the treating provider reports complaints of moderate, frequent, dull, achy and sore pain to the low back along with right lower extremity numbness and tingling, limited range of motion, and stiffness. The treating physician also notes neck stiffness and achiness. The treating physician requested Tylenol #3 300/30mg with a quantity of 60 noting use for chronic pain syndrome, Prilosec 20mg with a quantity of 30 for gastrointestinal protection/gastritis, Neurontin 300 mg with a quantity of 60 for neuropathic pain, and Voltaren Gel 1% 100 grams with a quantity of 2, but the documentation provided did not indicate the specific reason for requesting Voltaren gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tylenol 3 300/30 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: Per the referenced guidelines with the use of opiates for ongoing pain management there must be documentation of pain relief, functional status, appropriate medication use and side effects to the medications. There should be documented pain assessments with satisfactory response to treatment that would be indicated by the injured worker's decreased level of pain, increased functionality and improved quality of life. There should also be documentation of 4 A's for ongoing monitoring which would include analgesia, activities of daily living, adverse side effects and aberrant drug taking behaviors. Clinical information submitted does not provide documentation of the injured worker having any increase in functionality, decrease level of pain, or improved quality of life with the use of this medication. There were no recent urine drug screens provided in the medical record indicating that the injured worker is compliant with this current medication regimen. Given the information submitted for review the 4 A's of ongoing monitoring has not been addressed and the medical necessity of the request is not established. Therefore, the continued use of the medication Tylenol 3 300/30 mg #60 is not medically necessary.

Prilosec 20 mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The clinical information submitted does not provide documentation indicative that the injured worker is at high risk for gastrointestinal events. There is no documentation indicating that the injured worker is on concurrent use of aspirin, corticosteroids, or anticoagulant therapy. The injured worker does not have documented history of peptic ulcer, GI bleed or perforation to warrant the use of the requested medication, and she is under the age of 65. Given that there is no indication that the injured worker is at high risk for gastrointestinal events, medical necessity of continued use of this medication is not established and the request is not medically necessary.

Neurontin 300 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-18.

Decision rationale: Per the referenced guidelines, there should be documentation of a good response or a moderate response with the use of an antiepileptic medication. The continued use of antiepileptic drug depends on improved outcome versus tolerability of adverse effects. After

initiation of treatment there should be documentation of pain relief and improvement in function as well documentation of side effects incurred with use. The clinical information submitted does not provide any documentation that the injured worker having increased in functionality or decreased level in pain or improved quality of life with the use of this medication. Given the information submitted the medical necessity for the request has not been established and the request for Neurontin 300 mg #60 is not medically necessary.

Volteran Gel 1%100 grams: 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 the referenced guidelines, it stated that topical analgesic are largely experimental and generally recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Voltaren Gel 1% is indicative of the relief of osteoarthritis pain in joints that lend themselves to topical treatments such as the ankle, elbow, foot, hand, knee and wrist. It has not been evaluated for the treatment of the spine, hip, or shoulder. It is noted that the injured worker has complaints of her cervical spine, lumbar spine pain, and left shoulder strain. As there is no indication from the information submitted that the injured worker has had failed attempts at first line treatment with antidepressant or anticonvulsants to treat her condition prior to the use of the requested topical analgesic, and the referenced guidelines do not recommend the use of this medication for treatment of the spine, hip, or shoulder, the medical necessity of continued use is not established and the request for Volteran Gel 1% 100 grams is not medically necessary.