

Case Number:	CM15-0052006		
Date Assigned:	03/25/2015	Date of Injury:	12/01/2002
Decision Date:	05/12/2015	UR Denial Date:	03/12/2015
Priority:	Standard	Application Received:	03/19/2015

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 50-year-old female who reported injury on 12/01/2002. The mechanism of injury was not provided. Prior therapies and treatments, as well as diagnostic studies, included an MRI of the cervical spine, electrodiagnostic studies, an H-Wave, physical therapy, an ACDF at C4-6 on 07/09/2012, and urine drug screens. The injured worker's medications included Protonix, Voltaren, and Percocet as of 2012, and nortriptyline was added on 12/10/2014. There was a Request for Authorization submitted for review dated 03/05/2015. The documentation of 03/04/2015 revealed the injured worker had low back pain and right shoulder pain. The injured worker's pain with medications was an 8, and without medications, it was an 8.5. The current medications include Colace 100 mg, Senokot 187 mg, Voltaren 1% gel, Protonix 20 mg, Percocet 10/325 mg, and nortriptyline hydrochloride 25 mg capsules. The physical examination of the cervical spine revealed restricted range of motion, limited by pain. The Spurling's maneuver caused pain in the muscles of the neck. The diagnoses included cervical pain, cervical disc degeneration, and shoulder pain. The treatment plan included that the physician had tried to stop and wean the injured worker's Percocet; however, if the injured worker stopped or decreased medications, she was severely worsened with pain, and it was more difficulty to perform activities of daily living. The injured worker's quality of life without medications lessened so much so, the injured worker considered an emergency room visit. The injured worker was noted to have a CT of the cervical spine, and the physician reviewed the CT scan. The injured worker's GI symptoms were improved with Protonix. The injured worker's constipation was well controlled with Colace and Senokot. The heartburn was managed by

Protonix. The documentation indicated the medications provided functional benefit and pain relief. The Voltaren was noted to be utilized for the shoulder. The injured worker indicated that Percocet was working well to control pain and allowed for increased activities during the day. The injured worker indicated her pain score reduced from 10/10 to 6/10 with the medication. The injured worker was unable to get out of bed if she did not take Percocet. With medications, the injured worker could perform household tasks for 30 minutes at a time or greater. Without medications, she could not perform tasks for that long. The documentation indicated the injured worker would trial nortriptyline at night for neuropathic pain from radiculopathy, and as an adjunctive medication for sleep.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #180 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management, opioid dosing Page(s): 60, 78, 86. Decision based on Non-MTUS Citation website: <http://www.dea.gov/index.shtml>.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. Percocet is a schedule II medication and refills are not permitted. The clinical documentation submitted for review provided documentation the injured worker had an objective improvement in function, an objective decrease in pain, and documentation that the injured worker was being monitored for aberrant drug behavior and side effects. However, there was a lack of documentation indicating a necessity for a refill, as it is not recommended per the drug enforcement agency. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Percocet 10/325 mg #180 with 1 refill not identified as is not medically necessary.

Protonix 20mg #30 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines state proton pump inhibitors are recommended for injured workers at intermediate risk or higher for gastrointestinal events. They are also for the treatment of dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review indicated the injured worker had side

effects of heartburn and dyspepsia, which were controlled with the medication Protonix. However, there was a lack of documentation indicating a necessity for 1 refill without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Protonix 20 mg #30 with 1 refill not identified as is not medically necessary.

Voltaren 1% gel, #1 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics: Non-steroidal anti-inflammatory agents (NSAIDs) Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel Page(s): 112.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicate that Voltaren Gel 1% (diclofenac) is an FDA-approved agent indicated for relief of osteoarthritis pain in joints that lends themselves to topical treatment such as the 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 clinical documentation submitted for review indicated the injured worker had utilized the Voltaren gel for the shoulder. It has not been evaluated for treatment of the shoulder. There was a lack of documentation indicating a necessity for 1 refill without re-evaluation. The request as submitted failed to indicate the frequency and the body part to be treated. Given the above, the request for Voltaren 1% gel, #1 with 1 refill not identified as is not medically necessary.

Nortriptyline HCL 25mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The California Medical Treatment Utilization Schedule guidelines recommend antidepressants as a first line medication for treatment of neuropathic pain and they are recommended especially if pain is accompanied by insomnia, anxiety, or depression. There should be documentation of an objective decrease in pain and objective functional improvement to include an assessment in the changes in the use of other analgesic medications, sleep quality and duration and psychological assessments. The clinical documentation submitted for review indicated the injured worker had utilized the medication since 12/2014. There was a lack of documentation of an assessment in the changes in the use of other analgesic medications, sleep quality and duration, and psychological assessment. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Nortriptyline HCL 25 mg #30 not identified as is not medically necessary.