

Case Number:	CM15-0058946		
Date Assigned:	04/17/2015	Date of Injury:	06/04/1992
Decision Date:	07/17/2015	UR Denial Date:	03/09/2015
Priority:	Standard	Application Received:	03/27/2015

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: New York
 Certification(s)/Specialty: Emergency 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 53 year old female, who sustained an industrial injury on 06/04/1992. The initial complaints or symptoms included neck, right shoulder and mid pain. The initial diagnoses were not mentioned in the clinical notes. Treatment to date has included conservative care, medications, x-rays, MRIs, conservative therapies, electrodiagnostic testing, right elbow and wrist surgery (1992), and cervical spine fusion (2000 and 2014). Currently, the injured worker complains of continuous cervical spine pain with headaches and blurred vision, and continuous right upper extremity pain from the shoulder to the fingers with grinding, pinching and popping in the right shoulder. The diagnoses include multi-level cervical disc disease, status post multi-level fasciitis and revision fusion, right carpal tunnel syndrome, fibromyalgia, temporomandibular joint syndrome, depression, and migraines. The treatment plan consisted of medications (Voltaren, Zofran, Kera-tek analgesic gel, trazodone, Soma and Norco), 12 sessions of physical therapy, 12 sessions of occupational therapy, pain management consultation, and urine toxicology screening and follow-up.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren gel 1%; apply BID, 100mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic Page(s): 111-112.

Decision rationale: Voltaren is a non-steroidal anti-inflammatory agent. CA MTUS guidelines state that topical NSAIDs have been shown to have efficacy in the first 2 weeks of osteoarthritis, but afterwards efficacy diminishes. Voltaren Gel 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 spine, hip, or shoulder." The IW has ongoing neck pain. The records support the IW has been on this medication for a minimum of 2 months. The IW does not have a diagnosis of osteoarthritis. This exceeds the recommended 2 week. The request for Voltaren is not medically necessary.

Zofran 8mg one PO BID #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter, Ondansetron (Zofran).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter: antiemetics.

Decision rationale: The CA MTUS does not provide direction for the use of antiemetics. The Official Disability Guidelines recommends against their use for nausea presumed to be caused by chronic opioid intake. Ondansetron (Zofran) is FDA approved for nausea caused by chemotherapy and radiation treatment, postoperative use, and acute gastroenteritis. This injured worker does not have an FDA-approved indication, and the only apparent indication is for nausea possibly related to chronic opioid intake. The treating physician has not provided an adequate evaluation of any condition causing nausea. The necessary indications are not present per the available guidelines and evidence and the request for ondansetron is not medically necessary.

Physical therapy; 12 sessions 2x6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: CA MTUS chronic pain guidelines for manual therapy and manipulation are used in support of this decision. It is unclear from the submitted documentation if this is the first PT session or if this is a request for ongoing physical therapy for a chronic condition. Documentation does not clearly discuss the number of other physical medicine treatment or any

measure of functional improvement resulting from these treatments. Other conservative treatments with the exception of medications are not included in the chart materials. Previous pain medications were renewed without any mention of decreasing dosing or frequency. If this is a first request for treatment, guidelines support a trial of 6 visits over 2 weeks with evidence of functional improvements. If this is for ongoing care, guidelines do not recommend maintenance care. Rather, guidelines support "fading of treatment frequency along with active self-directed home PT." There is no mention of a home PT program in the records. The request for PT exceeds the recommended 6 first time sessions and if it is ongoing, maintenance therapy 12 visits are excessive. The request is not medically necessary.

Occupational therapy; 12 sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: CA MTUS chronic pain guidelines for manual therapy and manipulation are used in support of this decision. It is unclear from the submitted documentation if this is the first occupational medicine session or if this is a request for ongoing physical therapy for a chronic condition. Documentation does not clearly discuss the number of other physical medicine treatment or any measure of functional improvement resulting from these treatments. Other conservative treatments with the exception of medications are not included in the chart materials. Previous pain medications were renewed without any mention of decreasing dosing or frequency. If this is a first request for treatment, guidelines support a trial of 6 visits over 2 weeks with evidence of functional improvements. If this is for ongoing care, guidelines do not recommend maintenance care. There is no mention of a home therapy program in the records. The request for occupational medicine exceeds the recommended 6 first time sessions and if it is ongoing, maintenance therapy 12 visits are excessive. The request is not medically necessary.

Kera-Tek Analgesic Gel: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112. Decision based on Non-MTUS Citation <<http://www.drugs.com/search.php?searchterm=menthol>>.

Decision rationale: CA MTUS and ODG do not discuss methanol specifically. Other references report that methanol is a topical agent that has cooling properties when applied to skin or mucous membranes. It can be applied to skin for the treatment of pain. CA MTUS chronic pain guidelines discuss topical analgesics and state they are "largely experimental in use with few randomized controlled trials to determine efficacy or safety." Guidelines also state, "Many agents are compounded as monotherapy or in combination for pain control... There is little to no

research to support the use of many of these agents. Any compounded product that contains at least one drug that is not recommended is not recommended." The request for Menthol does not include dosing frequency, duration, or application site. Without this information and the lack of guideline support for topical agents, the request is not medically necessary.

Trazodone 100mg one PO QHS #30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG $i\frac{1}{2}$ pain chapter, insomnia.

Decision rationale: The MTUS does not address the use of hypnotics other than benzodiazepines. The Official Disability Guidelines were used instead. Note the ODG citation, which recommends short-term use of hypnotics, a careful analysis of the sleep disorder, and caution against using zolpidem in the elderly. Prescribing in this case meets none of the guideline recommendations. No physician reports describe the specific criteria for a sleep disorder. The reports do not show specific and significant benefit of trazodone. Sleep is routinely described as "poor", and the injured worker was stated to be sleeping 2-3 hours a night while taking trazodone. The treating physician has not addressed other major issues affecting sleep in this patient, including the use of other psychoactive agents like opioids, which significantly impair sleep architecture. Trazodone is not medically necessary based on prolonged use contrary to guideline recommendations, lack of benefit, and lack of sufficient evaluation of the sleep disorder.

Soma 350mg one PO Q8H PRN #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Page(s): 29.

Decision rationale: According to CAMTUS, Carisoprodol (Soma) is not recommended. Additionally, it is not recommended for long-term use. Medical records support the IW has been taking this medication for a minimum of 2 months. As this medication is not supported by guidelines, the request for Soma is determined not medically necessary