

Case Number:	CM14-0117078		
Date Assigned:	08/04/2014	Date of Injury:	10/07/2009
Decision Date:	09/26/2014	UR Denial Date:	06/26/2014
Priority:	Standard	Application Received:	07/24/2014

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 58-year-old male with a 10/7/09 date of injury, and status post right shoulder arthroscopy. At the time (6/26/14) of request for authorization for Percocet 10/325 mg X6, Soma 350 mg X 6, and Voltaren gel X 6, there is documentation of subjective complaints of pain and limited range of motion. Objective findings include right shoulder tenderness, limited range of motion. The injured worker's current diagnoses include shoulder pain, shoulder bursitis, shoulder osteoarthritis. Treatment to date includes activity modification and medications, including ongoing use of Voltaren gel and Percocet since at least 12/13. osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist), failure of an oral NSAID or contraindications to oral NSAIDs, an intention for short-term use (4-12 weeks), and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Voltaren gel use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325 mg X6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Opioids Page(s): 74-80.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of shoulder pain, shoulder bursitis, shoulder osteoarthritis. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; that the lowest possible dose is being prescribed; and that there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, given medical records reflecting prescription for Percocet since at least 12/13, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Percocet use to date. Therefore, based on guidelines and a review of the evidence, the request for Percocet 10/325 mg X6 is not medically necessary.

Soma 350 mg X 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Soma (Carisoprodol).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-64. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain).

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of acute exacerbation of chronic low back pain and used as a second line option for short-term treatment, as criteria necessary to support the medical necessity of muscle relaxant. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Official Disability Guidelines (ODG) identifies that muscle relaxants are recommended for short-term (less than two weeks) treatment. Within the medical information available for review, there is documentation of diagnoses of shoulder pain, shoulder bursitis, shoulder osteoarthritis. However, there is no documentation of an acute exacerbation of chronic pain and that Soma is being used as a second line option. In addition, given documentation of a request for Soma 350 mg X 6, there is no documentation of an intention for short-term treatment. Therefore, based on guidelines and a review of the evidence, the request for Soma 350 mg X 6 is not medically necessary.

Voltaren gel X 6: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Diclofenac.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory agents (NSAIDs Page(s): 111-112.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and short-term use (4-12 weeks), as criteria necessary to support the medical necessity of Voltaren Gel 1%. In addition, MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Official Disability Guidelines (ODG) identifies documentation of failure of an oral non-steroidal anti-inflammatory drugs (NSAIDs) or contraindications to oral NSAIDs, as criteria necessary to support the medical necessity of Voltaren Gel. Within the medical information available for review, there is documentation of diagnoses of shoulder pain, shoulder bursitis, shoulder osteoarthritis. However, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). In addition, there is no documentation of failure of an oral NSAID or contraindications to oral NSAIDs. Furthermore, given documentation of a request for Voltaren gel X 6, there is no documentation of an intention for short-term use (4-12 weeks). Lastly, given medical records reflecting prescription for Voltaren gel since at least 12/13, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Voltaren gel use to date. Therefore, based on guidelines and a review of the evidence, the request for Voltaren gel X 6 is not medically necessary.