

Case Number:	CM14-0145699		
Date Assigned:	09/12/2014	Date of Injury:	05/07/2012
Decision Date:	10/24/2014	UR Denial Date:	08/22/2014
Priority:	Standard	Application Received:	09/08/2014

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 Internal Medicine 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:

The injured worker is a 54-year-old female who reported an injury on 05/07/2012 due to a motor vehicle accident. On 03/24/2014, the injured worker presented with left shoulder pain. Upon examination, there was asymmetry with prominence at the left sternoclavicular joint but there was no instability. The bilateral shoulders elicited pain with overhead range of motion but there were no restrictions or limitations. The rotator cuff strength exhibited give way weakness against abduction and external rotation. The distal neurovascular examination was normal. Diagnoses were status post motor vehicle accident with persistent upper extremity, chest and upper back pain. A current medication list was not provided. The provider recommended Nucynta, Fioricet, and Voltaren gel. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nucynta 50MG #60: Upheld

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

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

Decision rationale: The request for Nucynta 50 mg #60 is not medically necessary. The California MTUS Guidelines recommend the use of opioids for ongoing management of chronic pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There was a lack of documentation of an objective assessment of the injured worker's pain level, functional status, evaluation of risks for aberrant drug abuse behaviors, and side effects. The efficacy of the previous use of the medication was not provided. Additionally, the provider's request did not indicate the frequency of the medication in the request as submitted. As such, the medical necessity has not been established.

Fioricet #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs) Page(s): 23.

Decision rationale: The request for Fioricet with a quantity of 30 is not medically necessary. The California MTUS Guidelines do not recommend barbiturates containing analgesics or Fioricet for chronic pain. The potential for drug dependence is high and there is no evidence to show a clinically important enhancement of analgesic efficacy due to barbiturate constituents. There is also a risk for medication overuse as well as a rebound headache. As the guidelines do not recommend barbiturates for chronic pain, Fioricet would not be indicated. Additionally, there was a lack of exceptional factors provided in the documentation submitted to support approving outside the guideline recommendations. The provider's request does not indicate the frequency or dose of the medication in the request as submitted. As such, the medical necessity has not been established.

Voltaren 1% Gel #100G Tube: 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.

Decision rationale: The request for Voltaren 1% gel with a quantity of 100 G tube is not medically necessary. The California MTUS Guidelines state that transdermal compounds are largely experimental in use with few randomized control trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended. The guidelines note that topical NSAIDs are recommended for osteoarthritis and tendinitis for joints amenable to topical treatments. Many agents are compounded as monotherapy or in combination for pain control, including NSAIDs, opioids, capsaicin, and local anesthetics. There is little to no research to

support the use of many of these agents. There was a lack of documentation that the injured worker had failed a trial of antidepressants or anticonvulsants. Additionally, the provider's request does not indicate the site at which the medication was indicated for or the frequency of the medication in the request as submitted. As such, the medical necessity has not been established.