

<b>Case Number:</b>	CM14-0166845		
<b>Date Assigned:</b>	10/14/2014	<b>Date of Injury:</b>	03/10/2009
<b>Decision Date:</b>	11/14/2014	<b>UR Denial Date:</b>	09/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/09/2014

### 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 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:

The injured worker is a 57-year-old female who sustained an injury on March 10, 2009. She is diagnosed with right shoulder pain status post decompression. She was seen for an evaluation on September 3, 2014. She reported complaints of right shoulder pain and intermittent numbness and tingling sensations throughout the right arm from the shoulder to the fingers. The examination of the upper extremity revealed swelling over the right shoulder. There was tenderness over the right shoulder and trapezius muscle. The range of motion of the right shoulder was limited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Methadone 10mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioid therapy Page(s): 93, 78-80, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Methadone Page(s): 61.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, methadone is recommended as a second-line drug for moderate to severe pain if the potential benefit outweighs the risk. There was no mention in the reviewed medical records that first-line

medications for moderate to severe pain were trialed and failed to warrant the necessity of methadone.

**Nucynta 100mg #180:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines): Pain: Tapentadol (Nucynta)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Tapentadol (Nucynta)

**Decision rationale:** As per the Official Disability Guidelines, this medication is recommended as second-line therapy for those who develop intolerable adverse effects from first-line opioids. Based on the reviewed medical records, there was no documentation that the injured worker trialed first-line opioids and, subsequently, was unable to tolerate its adverse effects. Proceeding with Nucynta 100 mg #180 is considered not medically necessary.

**Tizanidine 4mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs Page(s): 66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63.

**Decision rationale:** Tizanidine is recommended for the management of spasticity by the Chronic Pain Medical Treatment Guidelines. However, there were no clinical findings of spasms documented in the reviewed medical records. Therefore, medical necessity of this medication was not established based on the reviewed medical records.

**Voltaren 1% gel #500gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** According to the California Medical Treatment Utilization Schedule, there is little evidence to prove the efficacy of topical analgesics. Hence, the use of Voltaren gel is not medically necessary at this time.