

Case Number:	CM15-0066751		
Date Assigned:	04/14/2015	Date of Injury:	03/22/2010
Decision Date:	06/29/2015	UR Denial Date:	03/25/2015
Priority:	Standard	Application Received:	04/07/2015

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: Texas, New York, California
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 applicant is a represented 58-year-old [REDACTED] beneficiary who has filed a claim for chronic pain syndrome reportedly associated with an industrial injury of March 22, 2010. In a utilization review report dated March 25, 2015, the claims administrator failed to approve requests for Biofreeze Gel, Cymbalta, Voltaren Gel, and Neurontin. An RFA form received on March 16, 2015 was referenced in the determination. The claims administrator seemingly contended that the applicant had failed to profit from ongoing usage of several of the medications at issue. The applicant's attorney subsequently appealed. In a February 4, 2013 medical-legal evaluation, it was acknowledged that the applicant was receiving and/or had received Workers' Compensation Indemnity benefits, State Disability Insurance (SDI) benefits, and Social Security Disability Insurance (SSDI) benefits. The applicant's home had apparently been foreclosed upon, it was suggested. The applicant had been off of work for a protracted amount of time owing to various chronic pain and mental health issues, it was reported. In an RFA form dated March 15, 2015, Neurontin, Cymbalta, Voltaren Gel, and Biofreeze were endorsed. In an associated progress note of March 10, 2015, the applicant reported ongoing complaints of neck, bilateral upper extremity, and low back pain. The applicant was using Neurontin, Biofreeze Gel, Lidoderm patches, Voltaren Gel, and Cymbalta, it was reported. The applicant exhibited a flat and depressed affect. The applicant was not socializing owing to issues with anxiety and chronic pain syndrome. The applicant was not working. Permanent work restrictions were renewed. Multiple medications were also renewed. It was suggested that the request for Neurontin represented a renewal request for the same. The attending provider stated

that the Voltaren Gel could be employed for issues with tendonitis. Voltaren Gel was framed as a renewal request. Lidoderm patches were also framed as a renewal request. It was not clearly stated whether Cymbalta was a first-time request or a renewal request. It was suggested (but not clearly stated) that Cymbalta was being introduced for issues with chronic pain and depression. On August 7, 2014, it was stated that the applicant was using Neurontin, Biofreeze Gel, and Lidoderm patches. On December 11, 2014, the applicant was given refills of Lidoderm and Neurontin. There was no mention that the applicant was using Cymbalta at that point.

IMR ISSUES, DECISIONS AND RATIONALES

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

Biofreeze roll on #1 tube with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174; 299. Decision based on Non-MTUS Citation ODG Integrated Treatment/Disability Duration Guidelines Low Back Problems Biofreeze cryotherapy gel.

Decision rationale: Yes, the request for Biofreeze Gel was medically necessary, medically appropriate, and indicated here. Some of the applicant's primary pain generators were the neck and low back. The MTUS Guidelines in ACOEM Chapter 8, Table 8-5, page 174 and ACOEM Chapter 12, Table 12-5, page 299 both note that at-home local applications of heat and cold are recommended as methods of symptom control for neck, mid back, and/or low back pain complaints, as were/are present here. The Biofreeze Gel at issue represents a simple, low-tech means of delivering cryotherapy, which ODG's Low Back Chapter, Biofreeze Cryotherapy Gel Topic recommends as an optional form of cryotherapy. Biofreeze Gel, thus, was indicated, given its low cost and the favorable ACOEM and ODG positions on the same. Therefore, the request was medically necessary.

Cymbalta 30mg daily at bedtime #90 (3 month supply): Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine (Cymbalta) Page(s): 15.

Decision rationale: Similarly, the request for Cymbalta, an atypical antidepressant, was medically necessary, medically appropriate, and indicated here. Page 15 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that Cymbalta is FDA approved in the treatment of anxiety and depression, both of which were present here, and can be employed off label for radiculopathy, also present here. The attending provider seemingly framed the request as a first-time request for the same, initiated for the first time on or around March 10, 2015. Introduction of Cymbalta was indicated, given the applicant's decompensated mood and/or chronic pain complaints reported on that date. Therefore, the request was medically necessary.

Voltaren gel #3 tubes with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel 1% (diclofenac) Page(s): 112.

Decision rationale: Conversely, the request for Voltaren Gel was not medically necessary, medically appropriate, or indicated here. As noted on page 112 of the MTUS Chronic Pain Medical Treatment Guidelines, topical Voltaren has "not been evaluated" for the spine, hip, and/or shoulder. Here, the applicant presented with primary complaints of neck, mid back, and lower back pain on March 5, 2015. The applicant also had other pain generators, including the bilateral upper extremities, bilateral wrists, and periscapular musculature. It did not appear, in short, that the applicant's widespread multifocal pain complaints were readily amenable to topical application. Therefore, the request was not medically necessary.

Neurontin 300mg twice a day #180 (3 month supply): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin, Gabarone™, generic available) Page(s): 19.

Decision rationale: Finally, the request for Neurontin (gabapentin) was not medically necessary, medically appropriate, or indicated here. The request was a renewal or extension request for Neurontin (gabapentin), which the applicant had been using as early as August 7, 2014. Page 19 of the MTUS Chronic Pain Medical Treatment Guidelines stipulates that applicants on gabapentin should be asked "at each visit" as to whether there have been improvements in pain and/or function achieved as a result of the same. Here, however, the applicant was off of work, despite ongoing Neurontin (gabapentin) usage. Permanent work restrictions were renewed, unchanged, from visit to visit, despite ongoing Neurontin usage. The applicant was described as not actively participating in home exercise as of the March 5, 2015 office visit. It did not appear, in short, that ongoing usage of Neurontin (gabapentin) had effected any functional improvement in terms of the parameters established in MTUS 9792.20(e). Therefore, the request is not medically necessary.