

Case Number:	CM15-0073321		
Date Assigned:	04/23/2015	Date of Injury:	01/07/2005
Decision Date:	05/29/2015	UR Denial Date:	03/24/2015
Priority:	Standard	Application Received:	04/16/2015

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, Illinois

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:

This 68 year old woman sustained an industrial injury on 1/7/2005. The mechanism of injury is not detailed. Evaluations include electromyograms of the upper extremity dated 2/29/2012, 4/3/2008, 11/8/2007, 5/26/2005, and 4/16/2009, right shoulder MRIs dated 1/31/2008 and 7/6/2005, cervical spine MRIs dated 1/31/2008 and 9/9/2005. Diagnoses include cervical disc degeneration, right extremity pain, right shoulder pain, and cervical radiculopathy. Treatment has included oral and topical medications transforaminal epidural steroid injection, and selective epidural steroid injections. Physician notes dated 1/5/2015 show complaints of neck and right upper extremity pain rated 7/10. Recommendations include cervical sleeping pillow, Norco, continue TENS unit, encourage regular home exercise program and stretching, and follow up in four weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lyrica 50 mg, ninety count with three refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-19.

Decision rationale: The injured worker sustained a work related injury on 1/7/2005. The medical records provided indicate the diagnosis of cervical disc degeneration, right extremity pain, right shoulder pain, and cervical radiculopathy. Treatment has included oral and topical medications transforaminal epidural steroid injection, and selective epidural steroid injections. The medical records provided for review do not indicate a medical necessity for: Lyrica 50 mg, ninety count with three refills. Lyrica (Pregabalin) is an antiepileptic medication. The MTUS recommends the use of the antiepileptic drugs for the treatment of neuropathic pain. The guidelines recommends that continued use be based on evidence of 30 % reduction in pain, otherwise switch to a different first line agent, or combine with another first line agent. The records indicate the injured worker has been using this medication as far back as 08/2014, but there is no documentation of 30% pain reduction. Therefore the request is not medically necessary.

Norco 10/325 mg, sixty count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-88.

Decision rationale: The injured worker sustained a work related injury on 1/7/2005. The medical records provided indicate the diagnosis of cervical disc degeneration, right extremity pain, right shoulder pain, and cervical radiculopathy. Treatment has included oral and topical medications transforaminal epidural steroid injection, and selective epidural steroid injections. The medical records provided for review do not indicate a medical necessity for Norco 10/325 mg, sixty count. The MTUS recommends the use of the lowest dose of opioids for the short term treatment of moderate to severe pain. The MTUS does not recommend the use of opioids for longer than 70 days in the treatment of chronic pain due to worsening adverse effects and lack of research in support of benefit. Also, the MTUS recommends that individuals on opioid maintenance treatment be monitored for analgesia (pain control), activities of daily living, adverse effects and aberrant behavior. The MTUS recommends obtaining information from family members or other caregivers in determining the patient's response to treatment. The MTUS recommends discontinuation of opioid treatment if there is no documented evidence of overall improvement or if there is evidence of illegal activity or drug abuse or adverse effect with the opioid medication. The medical records indicate the injured worker has been on this medication since 2013 without documented overall improvement in pain. Although she is reported to have an improvement in activities of daily living, there is no objective documented improvement in function and quality of life. There is no evidence that her family members were involved in determination of her response to treatment. Therefore the request is not medically necessary.

Voltaren 1% gel, 100 gram tube with three refills: 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): 111-113.

Decision rationale: The injured worker sustained a work related injury on 1/7/2005. The medical records provided indicate the diagnosis of cervical disc degeneration, right extremity pain, right shoulder pain, and cervical radiculopathy. Treatment has included oral and topical medications transforaminal epidural steroid injection, and selective epidural steroid injections. The medical records provided for review do not indicate a medical necessity for Voltaren 1% gel, 100 gram tube with three refills. The medical records indicate the injured worker has been using this topical analgesic for at least one year. The Topical Analgesics are largely experimental drugs primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no documentation of failed treatment with antidepressant and anticonvulsant medications; besides, Voltaren Gel 1% (diclofenac) is only FDA approved for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist), not neck and shoulders. Therefore the request is not medically necessary.