

<b>Case Number:</b>	CM15-0095711		
<b>Date Assigned:</b>	05/22/2015	<b>Date of Injury:</b>	02/11/2008
<b>Decision Date:</b>	06/25/2015	<b>UR Denial Date:</b>	05/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/18/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 with an industrial injury dated 02/11/2008. The injured worker's diagnoses include traumatic degenerative disc disease arthritis of carpometacarpal joint of thumb, rupture of radial collateral ligament of thumb, unspecified disorder of autonomic nervous system, and reactive depression and pain in limb. Treatment consisted of diagnostic studies, prescribed medications, cognitive behavioral treatment, and periodic follow up visits. In a progress note dated 4/1/2015, objective findings revealed right tenderness in trapezius, decrease deep tendon reflexes, decrease grip , pain in forearm, positive carpal Tinel's and decrease range of motion in right wrist. In a progress note dated 4/3/2015, the injured worker reported pain throughout her body with the center of the pain in her right hand and arm with radiation. The treating physician reported refractory depression, poor eye contact, and psychomotor conversion shutdown of peripheral circulation. The treating physician prescribed Percocet 10/325 mg #30 refilled monthly for chronic neuropathic pain control and Voltaren gel 500 gm now under review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325 mg #30 refilled monthly for chronic neuropathic pain control: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-80, 92, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria For the Use of Opioids Page(s): 88-89, 76-78.

**Decision rationale:** The patient presents on 04/01/15 with whole pain rated 9+/10, primarily in her right upper extremity. The patient's date of injury is 02/11/08. Patient is status post unspecified surgeries to the right thumb and hand. The request is for Percocet 10/325 Mg #30 Refilled Monthly For Chronic Neuropathic Pain Control. The RFA was not provided. Physical examination dated 04/01/15 reveals decreased cervical range of motion in all planes, especially flexion, tenderness to palpation of the right trapezius, and positive Spurling's sign on the right. Shoulder examination reveals markedly decreased range of motion in the right shoulder on abduction, positive impingement sign to an unspecified shoulder, and reduced deep tendon reflexes bilaterally of Biceps, Triceps, and Brachioradialis muscles. Right wrist examination reveals decreased range of motion in all planes, especially flexion, positive Tinel's sign, positive Finkelstein's sign, and decreased/painful grip. The patient is currently prescribed Remeron, Atarax, Voltaren Gel, Tylenol 3, Clonazepam, Docusate sodium, Omeprazole, Celecoxib, Venlafaxine, and Zolpidem. Diagnostic imaging was not included. Per 04/01/15 progress note, patient is advised to return to work with modifications ASAP. MTUS Chronic Pain Medical Treatment Guidelines, page 88-89 Criteria For the Use of Opioids for Long-term Users of Opioids (6-months or more) states: Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument. MTUS page 78, Therapeutic trial of opioids, section on On-Going Management requires documentation of the 4As -analgesia, ADLs, adverse side effects, and adverse behavior, as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In regard to the continued use of Percocet for the management of this patient's chronic pain, the requesting provider has not provided adequate documentation of analgesia. This patient has been taking Percocet since at least 04/30/13. The most recent progress note, dated 04/01/15 does not provide any specific description of analgesia or functional improvement, stating: "The patient demonstrates increased activity and functionality on opiate therapy." It is documented that this patient's most recent UDS on 12/04/14 was consistent with prescribed medications, and that this patient does not display any aberrant behavior. However, without documentation of analgesia using a validated instrument, or activity-specific functional improvements attributed to narcotic medications, continuation of Percocet cannot be substantiated. Owing to a lack of complete 4A's as required by MTUS, the request is not medically necessary.

**Volteren gel 500 g.:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Pain Outcomes and Endpoints Page(s): 111-113, 9.

**Decision rationale:** The patient presents on 04/01/15 with whole pain rated 9+/10, primarily in her right upper extremity. The patient's date of injury is 02/11/08. Patient is status post unspecified surgeries to the right thumb and hand. The request is for Voltaren Gel 500G. The RFA was not provided. Physical examination dated 04/01/15 reveals decreased cervical range of motion in all planes, especially flexion, tenderness to palpation of the right trapezius, and positive Spurling's sign on the right. Shoulder examination reveals markedly decreased range of motion in the right shoulder on abduction, positive impingement sign to an unspecified shoulder, and reduced deep tendon reflexes bilaterally of Biceps, Triceps, and Brachioradialis muscles. Right wrist examination reveals decreased range of motion in all planes, especially flexion, positive Tinel's sign, positive Finkelstein's sign, and decreased/painful grip. The patient is currently prescribed Remeron, Atarax, Voltaren Gel, Tylenol 3, Clonazepam, Docusate sodium, Omeprazole, Celecoxib, Venlafaxine, and Zolpidem. Diagnostic imaging was not included. Per 04/01/15 progress note, patient is advised to return to work with modifications ASAP. The MTUS has the following regarding topical creams (p111, chronic pain section): "Topical Analgesics: Recommended as an option as indicated below. Non-steroidal anti-inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta- analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period... Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder." MTUS Chronic Pain Medical Treatment Guidelines, pg 9 under Pain Outcomes and Endpoints states: All therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement In regard to the continuation of Voltaren Gel, the requesting provider has not documented pain reduction or functional improvement attributed to this medication. MTUS allows for use of topical anti-inflammatory medications such as Voltaren for chronic pain of this nature. This patient has been prescribed Voltaren since at least 04/30/13, though there is no discussion of pain reduction or functional improvements specifically attributed to this medication. Most recent progress note, dated 04/01/15 does not include any discussion of Voltaren Gel efficacy, either. MTUS requires documentation of medication efficacy to substantiate continued use, none is provided. Therefore, the request is not medically necessary.