

Case Number:	CM13-0017099		
Date Assigned:	10/11/2013	Date of Injury:	08/01/2001
Decision Date:	04/17/2014	UR Denial Date:	08/06/2013
Priority:	Standard	Application Received:	08/27/2013

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 Occupational Medicine has a subspecialty in Preventive Medicine and is licensed to practice in New York, North Carolina. 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 patient is a 45-year-old female who reported an injury on 08/01/2001. The mechanism of injury was not stated. The patient is currently diagnosed with overuse syndrome of bilateral upper extremities, status post right carpal tunnel release in 2002, status post left carpal tunnel release in 2004, cervical strain, thoracic strain, lumbar strain with radiculopathy, bilateral shoulder strain, secondary muscle contraction headaches, insomnia, and GERD. The patient was seen by [REDACTED] on 07/16/2013. The patient reported persistent pain and numbness in bilateral upper extremities, with shoulder, neck, mid and low back pain. The patient also reported intermittent GERD, insomnia, and constipation. Physical examination revealed tenderness to palpation with spasm of the lumbar and cervical spine, positive straight leg raising, negative Spurling's maneuver, range of motion, positive impingement sign on the right, and moderate to severe hemiparesis. Treatment recommendation included continuation of current medications, including Voltaren gel and hydrocodone.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO 10/325MG, #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS. Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain over multiple areas of the body. There is no documentation of a functional improvement. Satisfactory response to treatment has not been indicated. Therefore, the request is non-certified.

VOLTAREN GEL 1% 100GM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

Decision rationale: Voltaren gel is indicated for the relief of osteoarthritis pain in joints that lend themselves to topical treatment. As per the documentation submitted, the patient does not maintain a diagnosis of osteoarthritis. Additionally, the patient has continuously utilized this medication. Satisfactory response to treatment has not been indicated. Therefore, the request is non-certified.