

Case Number:	CM13-0054045		
Date Assigned:	12/30/2013	Date of Injury:	06/05/2002
Decision Date:	03/18/2014	UR Denial Date:	10/30/2013
Priority:	Standard	Application Received:	11/19/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine, 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 physician 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 claimant is a 46 year old female who sustained a work-related injury on 6/5/02. Per a progress note dated 9/3/13, the claimant complained of low back pain, bilateral knee pain (primarily the left), and has had multiple episodes of instability. On exam, the left knee has 1+ effusion and limited range of motion with tenderness at the joint line. An MRI of the left knee on 4/22/13 was negative for recurrent meniscal tear or other structural abnormalities. A supplemental report dated 11/6/13 reports that the claimant has been under medical management for industrial injury involving her bilateral knees and lumbar spine. Multiple surgical procedures have been performed over the years. As a function of her industrial injury and subsequent surgeries she has developed a chronic pain syndrome which is being managed non-operatively.

IMR ISSUES, DECISIONS AND RATIONALES

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

30 Celebrex 200mg: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

Decision rationale: Per the Chronic Pain Medical Treatment Guidelines, COX-2 inhibitors (e.g., Celebrex) may be considered if the patient has a risk of GI complications, but not for the majority of patients. Generic NSAIDs and COX-2 inhibitors have similar efficacy and risks when used for less than three months, but a 10-to-1 difference in cost. There are no GI risk factors for this claimant that would justify the use of Celebrex over generic NSAIDs. The request for Celebrex is determined to not be medically necessary.

60 Hydrocodone/APAP 5/500mg: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80-81.

Decision rationale: The claimant is currently prescribed 10mg oral morphine equivalents per day. This is less than the Chronic Pain Guidelines' recommended ceiling of 120mg oral morphine equivalents per day. The claimant has also been on a stable medication regimen for over one year. Per the guidelines, the claimant is in a maintenance phase of chronic opioid pain management. Although there are precautions in such management by these guidelines, the provider reports that the claimant is being managed nonoperatively, and that there has been no abuse or diversion detected. The request is determined to be medically necessary.

30 Lidocaine 5%: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Per the Chronic Pain Medical Treatment Guidelines, Lidocaine (in patch form) is indicated for neuropathic pain after there has been evidence of a trial of first-line therapy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. There is no indication that the claimant is suffering from neuropathic pain where lidocaine may be useful. The request is determined to not be medically necessary.

500 Voltaren gel 1%: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67, 68, 111, 112.

Decision rationale: Voltaren gel 1% is an appropriate medication to apply to knees with arthritic pain. The recommendation of the guidelines quoted above is that topical NSAIDs only be used for short periods (up to 12 weeks) as the therapeutic effects diminish over time. The claimant does not appear to have been on this medication for an extended period of time. The request for pharmacy purchase of Voltaren Gel 1% #500 gm is determined to be medically necessary.