

Case Number:	CM13-0055819		
Date Assigned:	12/30/2013	Date of Injury:	05/25/1991
Decision Date:	03/26/2014	UR Denial Date:	10/22/2013
Priority:	Standard	Application Received:	11/21/2013

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 patient is an 82-year-old female who reported injury on 05/25/1991. The most recent documentation of 01/23/2013 revealed the patient's medications were Norco 10/325 and Voltaren gel 1%. The most recent examination revealed the patient had pain in the left shoulder and decreased range of motion. The patient had decreased left shoulder strength with lifting and was unable to raise their weight above the shoulder. The patient had pain on palpation of the right hip, right lower extremity, left shoulder, and arm. The diagnoses were noted to include lumbago, fibromyalgia, muscle weakness, malaise and fatigue, and spasms of muscle. The treatment of the lumbago was noted to be continue Norco 10/325 1 tablet by mouth every 4 hours as needed, continue Voltaren gel 1% as directed for transdermal headaches and cramps of the left arm; and due to numbness and tingling down the arm and hand, there was a recommendation for a cervical epidural for increased pain and headaches.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain Page(s): 60,78.

Decision rationale: California MTUS Guidelines indicate that opiates are appropriate for the treatment of chronic pain. There should be documentation of an objective increase in function, objective decrease in the VAS score, and evidence that the patient is being monitored for aberrant drug behavior and side effects. Clinical documentation submitted for review indicated the patient was undergone urine drug screens to monitor for aberrant drug behavior. There was a lack of documentation indicating an objective increase in function and objective decrease in the VAS score. Given the above, the request for 1 prescription of Norco 10/325 #180 is not medically necessary.

Voltaren gel #3: Upheld

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

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

Decision rationale: California MTUS indicates that Voltaren[®] Gel 1% (diclofenac) is an FDA-approved agent indicated for relief of osteoarthritis pain in joints that lends themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). Clinical documentation submitted for review failed to indicate the necessity for 3 tubes of Voltaren gel. There was a lack of documentation indicating the patient had osteoarthritis. Given the above, the request for 1 prescription of Voltaren gel 3 tubes, is not medically necessary.

An epidural cervical injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

Decision rationale: California MTUS guidelines recommend for an Epidural Steroid injection that Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing and it must be initially unresponsive to conservative treatment. Clinical documentation submitted for review failed to indicate the patient had objective physical findings of radiculopathy and failed to indicate the patient had corroboration of radiculopathy by imaging studies. Additionally, it failed to indicate that the patient's pain was initially unresponsive to conservative treatment. There was a lack of documentation indicating the laterality and the location for the injection. Given the above, the request for 1 cervical epidural injection is not medically necessary.