MAXIMUS Federal Services

Case Number:	CM14-0004775		
Date Assigned:	06/11/2014	Date of Injury:	11/01/2013
Decision Date:	12/03/2014	UR Denial Date:	12/27/2013
Priority:	Standard	Application Received:	01/10/2014

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 and is licensed to practice in Montana. 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 injured worker sustained an injury on 11/1/13 when she twisted the left knee. This injury has resulted in left knee pain which has been treated with tramadol, hydrocodone, Demerol and Toradol injections, hinged knee brace, physical therapy and use of a cane for assistance with ambulation. MRI of the left knee on 12/13/13 showed an acute subchondral fracture of the lateral tibial plateau with extensive bone marrow edema. There is also a complex tear of the medial and lateral menisci. There is chondral fraying of the medial aspect of the lateral tibial plateau and lateral irregularity of the medial femoral condyle. She has been referred to orthopedics. The treating physician has requested retro Norco #120, retro Voltaren XR #60, and retro Diflur Cream 25-10% (Fluribiprofen powder, diclofenac powder, Ultraderm cream base) 120 g #3.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETRO DIFLUR 25-10% CREAM (FLURBIPROFEN POWDER, DICLOFENAC SODIUM POWDER, ULTRADERM BASE CREAM) 120GM #3: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49,Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-112.

Decision rationale: The MTUS, in the ACOEM guidelines, states that, for initial treatment, topical medications are not recommended. This topical analgesic contains Flurbiprofen and diclofenac, which are nonsteroidal anti-inflammatory medications (NSAIDs). The MTUS states that topical nonsteroidal anti-inflammatory agents have not been shown to be effective in long-term studies. Topical non-steroidal antinflammatory agents have shown inconsistent efficacy in clinical trials 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. (Lin, 2004) (Bjordal, 2007) (Mason, 2004) When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. In this study the effect appeared to diminish over time and it was stated that further research was required to determine if results were similar for all preparations. (Biswal, 2006) These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. (Mason, 2004) Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lends themselves to topical treatment (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). The most common adverse reactions were dermatitis and pruritus. Topical treatment can result in blood concentrations and systemic effects comparable to those from oral forms, and caution should be used for patients at risk, including those with renal failure. (Krummel 2000) In this case the request for Diflur Cream is in addition to treatment with oral NSAIDs and the initial use of topical analgesics is not supported by the MTUS. This is an acute injury with no diagnosis of osteoarthritis. The request for retro Diflur Cream 25-10% (Flurbiprofen Powder, Diclofenac Sodium Powder, Ultraderm Base Cream) 120gm #3, is not medically necessary.

RETRO NORCO #120: 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 Opioids Page(s): 75, 78, 91.

Decision rationale: Norco is a brand name for hydrocodone, a short-acting opioid analgesic, combined with acetaminophen. The MTUS states that opioids are not recommended as first line therapy for neuropathic pain. Opioids are suggested for neuropathic pain that has not responded to first line recommendations including antidepressants and anticonvulsants. The MTUS states that reasonable alternatives to opioid use should be attempted. There should be a trial of non-opioid analgesics. When subjective complaints do not correlate with clinical studies a second opinion with a pain specialist and a psychological assessment should be obtained. The lowest possible dose should be prescribed to improve pain and function. Ongoing use of hydrocodone/acetaminophen requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: the least reported

pain over the period since the last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. The utilization review decision of 12/27/13 did modify the request for Norco #12, to certify 30 tablets. In this case the medical records show that the injured worker has been treated with tramadol. The records do not document pain relief, functional improvement or side effects. There is no documentation for the least reported pain over the period since the last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. The request for retro Norco #120 is not medically necessary.

RETRO VOLTAREN XR #60: 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 Nonsteroidal anti-inflammatory drug (NSAIDs) Page(s): 67-71.

Decision rationale: Voltaren (diclofenac) is a nonsteroidal anti-inflammatory drug (NSAID). The MTUS states that nonsteroidal anti-inflammatory medications are recommended at the lowest dose for the shortest period possible in patients with moderate to severe pain. Although NSAIDs are effective they can cause gastrointestinal irritation or ulceration. Studies also show that NSAID use for more than a few weeks can retard or impair bone, muscle, and connective tissue healing and may cause hypertension. Regarding neuropathic pain, the guidelines note inconsistent evidence for the use of these medications to treat long-term neuropathic pain but they may be useful to treat breakthrough pain. In this case the utilization review of 12/27/13 did approve the Voltaren XR with modification from #60 to #30. It recommended further use of Voltaren XR would be dependent on documentation of functional improvement. The provided records do not document functional improvement associated with Voltaren or other current treatments. The request for retro Voltaren XR #60 is not medically necessary.