

Case Number:	CM14-0100063		
Date Assigned:	07/28/2014	Date of Injury:	05/15/2001
Decision Date:	11/05/2014	UR Denial Date:	05/27/2014
Priority:	Standard	Application Received:	06/30/2014

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 Physical Medicine and Rehabilitation has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 is a 70-year-old female who reported an injury on 05/15/2001. The mechanism of injury was not provided for review. The injured worker's treatment history included surgical intervention, physical therapy, a TENS unit, injections and multiple medications. The injured worker reportedly sustained an injury to her right knee. The injured worker was evaluated on 05/01/2014. The injured worker's medications included Norco 10/325 mg and Voltaren gel 1%. It was noted that the injured worker had an unchanged pain level from the previous visit with an unchanged activity level. Physical findings included restricted range of motion described as 115 degrees in flexion of the right knee. Evaluation of the left knee documented limited range of motion described as 95 degrees in flexion with tenderness to palpation along the medial joint line and positive crepitus. The injured worker's treatment plan included continuation of meds and the use of a TENS unit. The injured worker was evaluated on 06/26/2014. It was documented that the injured worker's pain was largely unchanged from the previous visit. Physical findings remained unchanged from the previous visit. The injured worker's treatment plan remained unchanged from the previous visit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg, #120 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The requested Norco 10/325mg, #120 with 1 refill is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 01/2014. The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, a quantitative assessment of pain relief, managed side effects and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review did not provide any evidence that the injured worker is monitored for aberrant behavior in any way. Additionally, there is no documentation of functional improvement or quantitative assessment to support pain relief. Therefore, ongoing use of this medication would not be indicated in this clinical situation. Furthermore, the request, as it is submitted, does not clearly identify a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Norco 10/325mg, #120 with 1 refill is not medically necessary or appropriate.

Voltaren 1% Gel 100gm tube #5 with 1 refill: Upheld

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

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

Decision rationale: The requested Voltaren 1% gel 100gm tube #5 with 1 refill is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend the long term use of topical nonsteroidal anti-inflammatory drugs. The clinical documentation indicates that the injured worker has been on this medication since at least 01/2014. The California Medical Treatment Utilization Schedule generally limits the use of topical nonsteroidal anti-inflammatory drugs to approximately 4 weeks. Continued use of this medication would not be indicated in this clinical situation. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. Furthermore, the request, as it is submitted, does not clearly identify a frequency of treatment or an applicable body part. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Voltaren 1% gel 100gm tube #5 with 1 refill is not medically necessary or appropriate.