

Case Number:	CM14-0015161		
Date Assigned:	02/28/2014	Date of Injury:	03/08/2001
Decision Date:	07/22/2014	UR Denial Date:	01/28/2014
Priority:	Standard	Application Received:	02/06/2014

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, 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 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 56-year-old male who reported an injury on 03/08/2001. The mechanism of injury was not provided for clinical review. The diagnoses include lumbar pain and radiculopathy and bilateral sacroiliitis. Previous treatments include sacroiliac injections, physical therapy, HEP, and medication. The medication regimen includes Gabapentin, Hydrocodone, ibuprofen, Lidoderm patch, and Flector patch. Within the clinical note dated 01/13/2014, it was reported the injured worker complained of low back pain, and bilateral buttock and hip pain. Upon the physical exam the provider noted mild tenderness over the sacroiliac joints. The provider noted the injured worker had decreased sensory of the bilateral toes. He noted tenderness to the bilateral sacroiliac joints, pain with pelvic distraction test bilaterally, and pain with resisted abduction bilaterally. The provider requested Flector and Hydrocodone. However, a rationale was not provided for clinical review. The request for authorization form was submitted and signed but not dated.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION FOR FLECTOR PATCH 1.3%, #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Flector patch (diclofenac epolamine), Pages 56-57.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Flector patch (diclofenac epolamine).

Decision rationale: The request for 1 prescription for a Flector patch 1.3% #30 is non-certified. The injured worker complained of low back pain, and bilateral buttock and hip pain. The Official Disability Guidelines do not recommend Flector patch as a first line treatment. The Guidelines note where topical diclofenac is recommended for osteoarthritis after failure of an oral NSAID or contraindications to oral NSAIDs, after considering the increased risk profile with diclofenac, including topical formulations. Flector patch is FDA-indicated for acute strains, sprains, and contusions. The efficacy in clinical trials for topical NSAIDs have been inconsistent and most studies are small and of short duration. There is a lack of documentation indicating the injured worker has tried and failed on an oral NSAID. There is a lack of documentation indicating the injured worker was treated or diagnosed with osteoarthritis. The clinical documentation submitted does not warrant the medical necessity for the requested medication. In addition, the request does not specify a treatment site. The request submitted failed to provide the frequency of the medication. The request for 1 prescription for Flector patch 1.3% #30 is not medically necessary and appropriate.

PRESCRIPTION OF HYDROCODONE-ACETAMINOPHEN 10/325MG, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OPIOIDS (HYDROCODONE/ACETAMINOPHEN), Page(s): 79-80, 81. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

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

Decision rationale: The request for 1 prescription of Hydrocodone acetaminophen 10/325 mg #120 is non-certified. The injured worker complained of low back pain, and bilateral buttock and hip pain. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The Guidelines note a pain assessment should include current pain, 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 Guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. The provider did not document an adequate and complete pain assessment within the documentation. There is a lack of documentation indicating the medication had been providing objective functional benefit. Additionally, the use of a urine drug screen was not provided in the clinical documentation submitted. The request submitted failed to provide the frequency of the medication. The injured worker had been utilizing the medication since at least 04/2013. Therefore, the request for prescription of Hydrocodone acetaminophen 10/325 mg #120 is not medically necessary and appropriate.

