

Case Number:	CM14-0137840		
Date Assigned:	09/05/2014	Date of Injury:	04/15/1999
Decision Date:	10/06/2014	UR Denial Date:	08/15/2014
Priority:	Standard	Application Received:	08/26/2014

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 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:

Patient is a 65-year-old male with date of injury 04/15/1999. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 07/18/2014, lists subjective complaints as pain in the low back which extends down the calf and foot bilaterally. Objective findings: tenderness to palpation over the sacroiliac joints, bilaterally and lumbar paravertebral. Light touch and pinprick for bilateral lower extremities was intact. Motor tests were within normal limits. Straight leg tests were negative, positive Fortin sign, positive thigh thrust and positive compression. Diagnosis: 1. Right shoulder rotator cuff tears 2. Status post C3-7 fusion 3. Status post L4-S1 fusion 4. Bilateral cervical radiculopathy 5. Bilateral lumbar radiculopathy 6. Lumbar spondylosis. The medical records supplied for review document that the patient has been taking the following medications for at least as far back as 6 months. Medications: 1. Voltaren 1% gel SIG: apply three times per day as needed. 2. Norco 10/325mg, #60 SIG: 1 tab by mouth twice per day as needed.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 bilateral SI joint: 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), Sacroiliac Joint radiofrequency neurotomy. Official Disability Guidelines (ODG), Hip & Pelvis (Acute & Chronic), Facet joint diagnostic block.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis (Acute & Chronic), Sacroiliac joint radiofrequency neurotomy

Decision rationale: The ODG does not recommend sacroiliac joint radiofrequency neurotomy and states that the use of all techniques has been questioned, in part, due to the fact that the intervention of the SI joint remains unclear and that there is still controversy over the correct technique for radiofrequency denervation. Bilateral sacroiliac joint RFA is not medically necessary.

Voltaren 1% gel with 3 refills: 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, Non-steroidal anti-inflammatory agents drugs (NSAIDS)

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

Decision rationale: According to the Official Disability Guidelines, Voltaren gel is not recommended as a first as a first-line treatment, and is recommended only for osteoarthritis after failure of oral NSAIDs, or contraindications to oral NSAIDs, or for patients who cannot swallow solid oral dosage forms, and after considering the increased risk profile with diclofenac, including topical formulations. Voltaren 1% gel with 3 refills is not medically necessary.

Norco 10/325mg #60 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Norco and Nucynta, Hydrocodone/Acetaminophen; Opioids, criteria fo. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Tapentadol (Nucynta)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-94.

Decision rationale: A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of narcotic. The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of narcotics, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 6 months. Therefore, Norco 10/325mg #60 with 2 refills is not medically necessary.