MAXIMUS Federal Services

Case Number:	CM14-0061709		
Date Assigned:	08/08/2014	Date of Injury:	01/08/1997
Decision Date:	09/23/2014	UR Denial Date:	04/18/2014
Priority:	Standard	Application Received:	05/02/2014

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 & 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 underlying date of injury in this case is 01/08/1997. The mechanism of injury is that the patient hurt his low back when lifting and moving a ladder. The reported diagnoses include lumbosacral neuritis, shoulder pain, and status post right shoulder surgery. The patient has additionally been treated with medications, physical therapy, and deep tissue release. On 06/27/2014, the patient was seen in followup and noted improved low back pain with lessening radicular symptoms. The patient had been off work as his employer was unable to accommodate him. The patient was to attend acupuncture. The patient was not using Valium or Dilaudid but reportedly he kept them for use "just in case." The patient continued to use Norco, Soma, and Voltaren Gel. The patient's medications were continued.

IMR ISSUES, DECISIONS AND RATIONALES

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

Dilaudid 4mg, qty 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids/Ongoing Management Page(s): 78.

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on opioids/ongoing management, page 78, discuss the four A's of opioid management. In this case the medical records do not clearly indicate that the patient is taking this medication and do not outline any of the other elements in the four A's of opioid management with regard to Dilaudid. This is not supported by the treatment guidelines. This request is not medically necessary.

Ketamin 10%/Bupivacaine 1%/Diclofenac 3%/Doxepin 3%/Gabapentin 6%/Orphenadrine 5%/Pentoxifyline 3%, qty 240gm with 11 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on topical analgesics, state that any compounded product that contains at least one drug that is not recommended is not recommended. This guideline specifically does not recommend gabapentin for topical use and does not recommend muscle relaxants such as orphenadrine for topical use. Ketamine is recommended for topical use only in refractory situations when all other treatment options have failed. Overall the medical records do not discuss the mechanism of action or rationale for topical treatment in general or in particular topical treatment with multiple components. Additionally, 11 refills would not be appropriate without physician monitoring of the efficacy of such treatment. For these multiple reasons, this request is not medically necessary.

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

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids/Ongoing Management Page(s): 78.

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on opioids/ongoing treatment, page 78, discuss the four A's of opioid management, recommending ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The details are not documented in this case. A rationale or indication for ongoing opioid use is not apparent at this time. This request is not medically necessary.

Valium 10mg, qty 90 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on benzodiazepines, page 24, state that this category of medication is not recommended for long-term use. The medical records do not provide alternate rationale for its use; rather, the treatment records suggest that the patient is not currently actively utilizing this medication. This request is not supported by the treatment guidelines. This request is not medically necessary.

Voltaren gel 1%, 500mg with 5 refills: Upheld

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

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

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on topical analgesics, discuss topical anti-inflammatory medications on page 111. The guideline states that this class of medication is generally indicated only for short term use. Additionally, Voltaren Gel specifically has not been evaluated for treatment of the spine. For multiple reasons, the records and guidelines so not support any indication or benefit from this requested medication. This request is not medically necessary.