

Case Number:	CM14-0094837		
Date Assigned:	07/25/2014	Date of Injury:	07/23/2010
Decision Date:	09/09/2014	UR Denial Date:	05/22/2014
Priority:	Standard	Application Received:	06/23/2014

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 Nevada. 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 records presented for review indicate that this 48 year old individual was reportedly injured on July 23, 2010. The mechanism of injury is undisclosed. The most recent progress note, dated July 1, 2014 indicates that there are ongoing complaints of right knee, neck and headache pain. The physical examination demonstrated an individual in mild discomfort, there is tenderness over the Paris cervical spinal musculature with muscle spasm, a decrease in cervical spine range of motion is reported, motor function in the left upper extremities noted be 4/5 and deep tendon reflexes are 1+. The lumbar spine examination noted tenderness to palpation, muscle spasms, a decrease in lumbar spine range of motion, and no motor function. Diagnostic imaging studies objectified were not reported. Previous treatment includes two separate knee surgeries, epidural steroid injections, medial branch nerve blocks, medial branch rhizotomy and other pain management interventions. A request was made for multiple medications and was not certified in the preauthorization process on May 22, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription of Norco 10/325mg #15 with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78.

Decision rationale: As noted in the Medical Treatment Utilization Schedule (MTUS), this medication is indicated for the short term management of moderate to severe breakthrough pain. This medication should include the lowest possible dose, objectification of improvement in pain and function, with the ongoing review and documentation of pain relief. The most recent progress notes indicate a 40 percent decrease in the pain complaints, however the physical examination, overall functionality and return to work status to support that the termination. It is also noted that a previous reviewer allowed for a partial certification so as to beginning weaning protocol and this was not pursued. The medical necessity for Norco has not been established.

1 Prescription of Traxodone 50mg #30 with 3 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Non-Steroidal Anti-Inflammatory Agents (NSAIDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122.

Decision rationale: As outlined in the Medical Treatment Utilization Schedule (MTUS), this medication has an indication to treat several issues one which is insomnia. The records reflect a slightly increased sleep pattern with one half tablet of this medication per night. Therefore, the medical necessity for the continued use of Traxodone 50mg #30 with 3 refills has been established.

Voltaren gel 1% #500g with 3 refills: Upheld

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

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

Decision rationale: As outlined in the Medical Treatment Utilization Schedule (MTUS), this medication is indicated to treat osteoarthritis pain in joints. There is no clear clinical indication presented in the progress note that this particular medication is having any noted affect. Therefore, the medical necessity for Voltaren gel is not established.