MAXIMUS Federal Services

| Case Number: | CM14-0175090 | | |
|---|---|---|---|
| Date Assigned: | 12/12/2014 | Date of Injury: | 03/11/1992 |
| Decision Date: | 05/22/2015 | UR Denial Date: | 10/13/2014 |
| Priority: | Standard | Application Received: | 10/22/2014 |

## 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Utah, Arkansas
Certification(s)/Specialty: Family Practice, Sports Medicine

## 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 63-year-old male, who sustained an industrial injury on 3/11/1992. The mechanism of injury was not noted. The injured worker was diagnosed as having traumatic amputation of left above the knee, posttraumatic stress disorder, severe depression, erectile dysfunction, displacement of lumbar intervertebral disc without myelopathy, multi -level disc bulges of the lumbar spine, knee internal derangement, ankle/feet sprain, headaches, and memory loss. Treatment to date has included diagnostics, transcutaneous electrical nerve stimulation unit, interferential unit, lumbar support, and medications. On 9/25/2014, the injured worker complained of throbbing head pain (rated 8/10), low back pain with radiation to his lower extremities (rated 6-7/10), and left thigh pain (rated 7/10). Reported pain levels were noted as with medication use. Current medication use included Viagra, Fentanyl, Neurontin, and Voltaren gel. The treatment plan included diagnostics and medications, including Percocet and Flector.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, page(s) 75-79.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The MTUS indicates that ongoing management of opioids includes documentation of prescriptions given from a single practitioner, prescriptions from a single pharmacy and the lowest dose should be used to improve function. There should also be an ongoing review of the 4A's, including analgesia, activities of daily living, adverse side effects, and aberrant drug behaviors. There is no clear functional gain that has been documented with this medication. Guidelines state that the discontinuation of opioid medication is recommended if there is no overall improvement in function. According to the clinical documentation provided and current MTUS guidelines; Percocet is not indicated a medical necessity to the patient at this time.

**Flector pain patches:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines page 112. Diclofenac.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Topical Diclofenac. MTUS guidelines state the following: Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. The patient currently lacks documentation of a diagnosis for osteoarthritis. According to the clinical documentation provided and current MTUS guidelines, Topical Diclofenac is not indicated as a medical necessity to the patient at this time.