

Case Number:	CM15-0005424		
Date Assigned:	01/16/2015	Date of Injury:	04/21/2002
Decision Date:	04/16/2015	UR Denial Date:	01/08/2015
Priority:	Standard	Application Received:	01/10/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 45-year-old female who reported an injury on 04/21/2002. The mechanism of injury was a fall. The injured worker's diagnoses included rotator cuff sprains and strains, pain in joint of lower leg, unspecified disorders of shoulder bursae and tendon in shoulder region, and joint derangement not elsewhere classified of multiple sites. The injured worker's past treatments included physical therapy, chiropractic therapy, ice treatment, and medications. The injured worker's surgical history included a rotator cuff and arthroscopic knee surgery, performed in 2012. On 12/31/2014, the injured worker reported a pain level of 6/10 on a pain scale. She reported cramping in her arms bilaterally and neck pain worse on the right side. She complained of bilateral knee pain, ankle pain, and right hip pain. She reported that since switching from Norco to Ultracet, her functioning decreased. She continued to ambulate with a cane. She reported numbness in her anterior legs bilaterally and all of her toes, except the big toe. She joined a gym, but had not been back in several weeks. Upon physical examination, the injured worker was noted with painful neck movements with extension beyond 10 degrees, right lateral bending beyond degrees 20, left lateral bending beyond 20 degrees, and lateral rotation to the left and right beyond 10 degrees. She could not heel walk because of her hip pain. The request was for Norco 10/325 mg #90 for pain control.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80.

Decision rationale: The request for Norco 10/325 mg #90 is not medically necessary. According to the California MTUS Guidelines, continuation of opioid therapy may be recommended for patients with ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include a current quantified pain, the least reported pain over the period since last assessment, the intensity of pain after taking the opioid, and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids including pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant drug related behaviors. The injured worker reported a pain level of 6/10 on the date of evaluation. She reported Ultracet was very effective for her pain and her sleep had improved as well. She then stated that since switching from Norco to Ultracet, her functioning has decreased. Upon physical examination, the injured worker was noted with painful neck movements and assisted ambulation. The documentation did not provide sufficient evidence of significant objective decrease in pain as a result of the use of the medication, documented evidence of significant objective functional improvement as the result of medication use. Documentation indicates the injured worker was using Norco since at least 01/2014. In the absence of documentation with sufficient evidence of significant objective decrease in pain and a significant objective functional improvement as a result of the use of Norco, the request is not supported. Additionally, as the request was written, there was no frequency provided. Therefore, the request is not medically necessary.

Voltaren gel 1% 4 grams QTY: 1: Upheld

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

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

Decision rationale: The request for Voltaren gel 1% 4 grams QTY: 1 is not medically necessary. According to the California MTUS Guidelines, topical analgesics are largely experiment in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2 week period. Voltaren gel has not been evaluated for treatment of the spine, hip, or shoulder. The injured worker reported a

pain level of 6/10 on a pain scale. The documentation indicates the injured worker has been using Voltaren gel since at least 07/2014. The documentation did not provide sufficient evidence of significant objective decrease in pain as a direct use of the medication. The documentation did not provide sufficient evidence of significant objective functional improvement as a result of the use of the medication. In the absence of documentation with sufficient evidence of significant objective functional improvement and significant objective decrease in pain as a result of the use of the medication, the request is not supported. Additionally, as the request was written, there was no frequency or specified location to apply the gel provided. As such, the request is not medically necessary.