

Case Number:	CM15-0102438		
Date Assigned:	06/04/2015	Date of Injury:	01/09/1999
Decision Date:	07/07/2015	UR Denial Date:	05/12/2015
Priority:	Standard	Application Received:	05/28/2015

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: Preventive Medicine, Occupational 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 71 year old male injured worker suffered an industrial injury on 01/09/1999. The diagnoses included cervical strain, right shoulder strain, right and left epicondylitis, bilateral hand/wrist repetitive strain injuries with bilateral numbness and tingling, bilateral upper extremity repetitive strain injury and chronic pain. The injured worker had been treated with medications and physical therapy. On 3/10/2015 exam there was slight tenderness about the upper back, neck, both hands and wrists with reduced cervical range of motion. The treatment plan included Thermacare Pack, Voltaren gel, and Acetaminophen-Codeine #3.

IMR ISSUES, DECISIONS AND RATIONALES

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

Thermacare Pack #30 with 6 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48. Decision based on Non-MTUS Citation www.thermacare.com.

Decision rationale: MTUS guidelines support the use of heat and cold during the acute to subacute phases of injury for a period of 2 weeks or less. MTUS Guidelines and OGD do not address the use of thermacare. Per manufacturers information thermacare provides patented heat relief from back, hip, neck, knee, shoulder, elbow, wrist, and menstrual pain. The injured worker is being treated for chronic pain without evidence of acute exacerbation, therefore, the request for Thermacare Pack #30 with 6 refills is determined to not be medically necessary.

Voltaren gel 1% with 2 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section Page(s): 111-113.

Decision rationale: Per the MTUS Guidelines, the use of topical analgesics is recommended as an option for some 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. When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. Voltaren Gel 1% is FDA approved and 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. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The injured worker has been prescribed voltaren Gel for an extended period without documentation of relief of pain specifically from the use of voltaren. Voltaren gel is not recommended for long term use. The request for Voltaren gel 1% with 2 refills is determined to not be medically necessary.

Acetaminophen-Codeine #3 300/30mg #60 with 2 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Section, Weaning of Medications Section Page(s): 74-95, 124.

Decision rationale: The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. The medical documentation reports that the injured worker is on chronic pain medications and she needs these medications to remain functional. The requesting physician is also taking measures to assess for aberrant behavior that may necessitate immediate discontinuation of the medications. The injured worker's opioid medication dosing has remained stable and, and she appears to be in a maintenance stage of her pain management. The request for Acetaminophen- Codeine #3 300/30mg #60 with 2 refills is determined to be medically necessary.