

Case Number:	CM15-0016193		
Date Assigned:	02/04/2015	Date of Injury:	02/23/2005
Decision Date:	03/13/2015	UR Denial Date:	01/07/2015
Priority:	Standard	Application Received:	01/28/2015

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: Texas, Illinois

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 injured worker is a 57 year old male, who sustained an industrial injury on February 23, 2005. He has reported back, shoulder and leg pain. The diagnoses have included cervical discogenic syndrome, cervical radiculitis, lumbar degenerative disc disease (DDD), lumbar stenosis, tenosynovitis of foot and/or ankle, knee or leg sprain/strain and shoulder impingement syndrome. Treatment to date has included medication and Transcutaneous Electrical Nerve Stimulation (TENS) unit. Currently, the Injured worker complains of neck pain radiating to back and shoulder, low back pain radiating down legs and right shoulder pain. Treatment includes Transcutaneous Electrical Nerve Stimulation (TENS) unit, injections, and medication. On January 7, 2015 utilization review non-certified a request for Voltaren gel 1% #1 and modified a request for Norco 5/325mg #60. The Medical Treatment Utilization Schedule (MTUS) Chronic Pain guidelines were utilized in the determination. Application for independent medical review (IMR) is dated January 26, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5/325 #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the Use of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-81.

Decision rationale: The injured worker sustained a work related injury on February 23, 2005. The medical records provided indicate the diagnosis of cervical discogenic syndrome, cervical radiculitis, lumbar degenerative disc disease (DDD), lumbar stenosis, tenosynovitis of foot and/or ankle, knee or leg sprain/strain and shoulder impingement syndrome. Treatment to date has included medication and Transcutaneous Electrical Nerve Stimulation (TENS) unit. The medical records provided for review do not indicate a medical necessity for Norco 5/325 #60. The MTUS recommends the opioids for short term treatment of chronic pain, since it has not been tested for treatment of chronic pain beyond 70 days. The records indicate the injured worker has been using opioids for at least one year, but the most recent records indicate increasing pain. The MTUS recommends to discontinue opioids if there is no improvement in pain or function.

Voltaren Gel 1% #1: Upheld

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

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

Decision rationale: The injured worker sustained a work related injury on February 23, 2005. The medical records provided indicate the diagnosis of cervical discogenic syndrome, cervical radiculitis, lumbar degenerative disc disease (DDD), lumbar stenosis, tenosynovitis of foot and/or ankle, knee or leg sprain/strain and shoulder impingement syndrome. Treatment to date has included medication and Transcutaneous Electrical Nerve Stimulation (TENS) unit. The medical records provided for review do not indicate a medical necessity for Voltaren Gel 1% #1. The MTUS recommends the use of this medication 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 records do not indicate the injured worker has osteoarthritis of knee, ankle, elbow hand or foot or wrist. Beside, there is no documentation of failed treatment with oral Medications. Furthermore, the Official Disability Guidelines recommends against the use of diclofenac(Voltaren) as first line drug due to the high risk profile. The requested treatment is not medically necessary and appropriate.