

Case Number:	CM15-0163059		
Date Assigned:	08/31/2015	Date of Injury:	04/03/1997
Decision Date:	10/19/2015	UR Denial Date:	08/11/2015
Priority:	Standard	Application Received:	08/19/2015

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: New York
 Certification(s)/Specialty: Internal 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 58 year old male injured worker suffered an industrial injury on 4-3-1997. The diagnoses included thoracic spine bulge, depression, lumbar pain with sacroiliac radiculopathy, chronic cervical protrusion and motor weakness of the right wrist. The treatment included medications and TENS unit. The diagnostics included cervical magnetic resonance imaging. On 7-30-2015 the treating provider reported he was very depressed. The cervical pain was rated 3 to 7 out of 10. He had radiation of pain to the right hand. The mid spine pain was rated 5 to 7 out of 10. He reported he is getting fewer migraines because of Topamax and the epidural. There were trigger points in the cervical, upper back and thoracic region which twitch and radiate. He was given a Toradol injection which alleviated pain by 55%. The total of Morphine Equivalent Dose was 420 MED with the combination of the Hydrocodone and Oxycontin. The injured worker had not returned to work. The requested treatments included Hydrocodone-Acetaminophen 10/325mg, Ketorolac 60mg inject, and Voltaren 1% gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone-Acetaminophen 10/325mg take 1 tab up to 6/day for breakthrough pain
 #180: Upheld**

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: MTUS recommends that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects must be documented with the use of Opioids. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Guidelines recommend using key factors such as pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors, to monitor chronic pain patients on opioids. Assessment for the likelihood that the patient could be weaned from opioids is recommended if there is no overall improvement in pain or function, unless there are extenuating circumstances and if there is continuing pain with the evidence of intolerable adverse effects. Documentation fails to demonstrate objective evidence of adequate improvement in level of function or pain, to support the medical necessity for continued use of opioids. Furthermore, the Morphine Equivalent Dose with the combination of Oxycontin and Hydrocodone was 420 MED which exceeded the maximum recommendation of 120 MED. The request for Hydrocodone-Acetaminophen 10/325mg take 1 tab up to 6/day for breakthrough pain #180 is not medically necessary by MTUS.

Ketorolac 60mg inject 2ml 60mg Intramuscularly, no more than twice/week for pain #18m:
Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAID (anti-inflammatory drugs) Ketorolac.

Decision rationale: MTUS was silent. Per ODG, Ketorolac injection is indicated in the management of moderately severe acute pain as an alternative to opioid therapy. It is not recommended for chronic painful conditions. Ketorolac injection may also be administered as an option to corticosteroid injections for shoulder pain, with up to three injections. It is recommended that patients receiving Ketorolac injections not take concurrent oral NSAIDs due to potential side effect of bleeding. Physician report at the time of the requested service under review fails to show acute exacerbation of symptoms. The medical necessity for Ketorolac injection is not established. The request for Ketorolac 60mg inject 2ml 60mg Intramuscularly, no more than twice/week for pain #18m is not medically necessary.

Voltaren 1% gel, apply 4 grams, 4 times/day Max 16gm/single joint, #100gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Voltaren Gel 1% (diclofenac) is a topical nonsteroidal anti-inflammatory drug (NSAID) indicated for short-term treatment (4-12 weeks) of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Per MTUS, topical NSAIDS are not recommended for neuropathic pain. The documentation provided fails to show that the injured worker is diagnosed with Osteoarthritis or tendonitis of a joint that would fit the recommended criteria for using Voltaren gel. The request for Voltaren 1% gel, apply 4 grams, 4 times/day Max 16gm/single joint, #100gm is not medically necessary.