MAXIMUS Federal Services

Case Number:	CM15-0197906		
Date Assigned:	10/13/2015	Date of Injury:	01/28/2009
Decision Date:	12/16/2015	UR Denial Date:	09/22/2015
Priority:	Standard	Application Received:	10/08/2015

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 injured worker is a 52 year old female who sustained an industrial injury on 01-28-2009. According to the most recent progress report submitted for review and dated 08-25-2015, the injured worker had a history of chronic low back and left leg pain in the setting of lumbar degenerative disc disease with radiculopathy and facet osteoarthritis. Without medications, pain was rated 10 on a scale of 1-10. With medications pain was rated 6. She reported that she fell again at home this month. In the past, she had "significant" pain relief and increased activities from epidurals which helped eliminate her leg pain. Medications included Therma Care wrap, Norco, Voltaren Gel, Gabapentin and an unknown diuretic prescribed by her primary care physician. The injured worker reported that without medications, she was essentially bed bound due to pain and able to tolerate being upright only enough to ambulate with a walker to and from the bathroom and for meals. She could do "very little" activities of daily living. Epidurals helped increase her mobility and function. Physical examination demonstrated severe tenderness to palpation over the lumbosacral region at the L4-S1 levels. Straight leg raise was positive. Flexion was 90% restricted. Extension was 50% and lateral bending was 90% restricted. Compression and facet loading maneuver was positive. Hypoesthesia of toes and lateral calves were noted. MRI performed in 2011 showed a left neural foraminal disk protrusion, facet hypertrophy throughout, L4-5, L5- S1 bilateral foraminal narrowing. Diagnoses included degeneration of thoracic or lumbar intervertebral disc, lumbago, other symptoms referable to back, pain in joint pelvic region and thigh and chronic back pain. The treatment plan included continuance of pain medication regimen: Norco, Neurontin, Voltaren 1% gel and Therma Care Wraps. Follow up

was indicated in 1 month. An authorization request dated 08-25-2015 was submitted for review. The requested services included Norco 10-325 mg 1 four times a day as needed #120, Neurontin 300 mg 3 twice a day #180, Voltaren Gel 1% apply 2-4 grams four times a day #3 and Therma Care Wraps #3 boxes. Documentation submitted for review dated back to 06-16-2015 and showed use of Norco, Gabapentin, Voltaren Gel 1% and Therma Care Wraps at that time. Urine toxicology reports were not submitted for review. On 09-22-2015, Utilization Review modified the request for Norco 10-325 mg #120 and Neurontin 300 mg #180 and non-certified the request for Voltaren Gel 1% #3 and Therma Care Wraps #3 boxes.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 MG #120: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. The MTUS states that opioids may be continued, (a) If the patient has returned to work, or (b) If the patient has improved functioning and pain. There is no documentation that the patient fits either of these criteria. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of narcotic. Norco 10/325 MG #120 is not medically necessary.

Neurontin 300 MG #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: The MTUS states that gabapentin is an anti-epilepsy drug which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. An adequate trial period for gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. With each office visit the patient should be asked if there has been a change in the patient's pain symptoms, with the recommended change being at least 30%. There is no documentation of any functional improvement. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly. Neurontin 300 MG #180 is not medically necessary.

Voltaren Gel 1 Percent #3: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Voltaren Gel (Diclofenac).

Decision rationale: According to the Official Disability Guidelines, Voltaren gel is not recommended as a first as a first-line treatment, and is recommended only for osteoarthritis after failure of oral NSAIDs, or contraindications to oral NSAIDs, or for patients who cannot swallow solid oral dosage forms, and after considering the increased risk profile with diclofenac, including topical formulations. Documentation in the medical record does not meet guideline criteria. Voltaren Gel 1 Percent #3 is not medically necessary.

Therma Care Wraps #3 Boxes: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Cold/heat packs.

Decision rationale: The Guidelines recommended cold/heat packs as an option for acute pain. The age of the patient's claim indicates it is well past the acute phase of the injury. Therefore, this request is not medically reasonable at this time. Therma Care Wraps #3 Boxes is not medically necessary.