

Case Number:	CM15-0207863		
Date Assigned:	10/26/2015	Date of Injury:	08/08/2007
Decision Date:	12/08/2015	UR Denial Date:	10/15/2015
Priority:	Standard	Application Received:	10/22/2015

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: Ohio, West Virginia

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Medical Toxicology

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 56-year-old female, who sustained an industrial injury on August 8, 2007, incurring low back and right knee injuries. She was diagnosed with lumbar degenerative disc disease with disc bulging, lumbar radiculopathy, and right knee osteoarthritis. Treatment included pain medications, neuropathic medications, topical analgesic gel, antidepressants, and activity restrictions. In January 2012, the injured worker underwent a right total knee replacement. Currently, the injured worker complained of persistent lower backaches and right knee pain. She rated her pain with medications 5 on a scale of 1 to 10 and without medications 10 out of 10. Upon examination, she was noted to have restricted range of motion with pain and tenderness in the lumbar region. Her pain had been managed on her current medication regimen. Her activities of daily living were improved on the current dose of medications. A urine drug screen was consistent with her medications. The treatment plan that was requested for authorization included prescriptions for Nucynta 75 mg #90 with 1 refill and Voltaren 1% gel #3 with 1 refill. On October 15, 2015, a request for prescriptions for Nucynta and Voltaren gel was denied by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nucynta 75mg #90 with 1 refill: 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), Pain, Tapentadol (Nucynta).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain, Opioids, dosing, Opioids, specific drug list. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Pain, Opioids.

Decision rationale: ODG does not recommend the use of opioids for low back pain "except for short use for severe cases, not to exceed 2 weeks." The IW has exceeded the 2 week recommended treatment length for opioid usage, having been on the current medication regimen for as much as 6 months. MTUS does not discourage use of opioids past 2 weeks, but does state that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; 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." The treating physician does not fully document the least reported pain over the period since last assessment, increased level of function or if the IW is reducing use of medication and showing continued improvement. In addition; Nucynta is not a first line medication and no documentation is provided detailing the failure of first line opioids, in fact other opioids are in use in conjunction with this medication. The available medical record does not support continued treatment per guidelines and weaning should occur. As such, the request for Nucynta 75 mg #90 is deemed not medically necessary.

Voltaren 1% gel #3 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steriodal anti-inflammatory drugs), Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

Decision rationale: MTUS and ODG recommend usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states that topical NSAIDs are "Recommended for short-term use (4-12 weeks.)" MTUS specifically states for Voltaren Gel 1% (diclofenac) that is it "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." Medical records indicate that this medication was prescribed for knee OA that per MTUS is an acceptable indication, however, the IW has been using this topical for as much as 6 months, longer then the recommended 12 weeks of short-term utilization. As such, the request for Voltaren 1% gel #3 with 1 refill is deemed not medically necessary.