

Case Number:	CM15-0053857		
Date Assigned:	03/27/2015	Date of Injury:	09/22/2011
Decision Date:	05/06/2015	UR Denial Date:	02/26/2015
Priority:	Standard	Application Received:	03/23/2015

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 49-year-old male, who sustained an industrial injury on 9/22/11. He reported right knee pain. The injured worker was diagnosed as having bilateral knee pain with medial meniscus injury. Treatment to date has included right knee arthroscopy with resection of torn portion of the lateral meniscus, tricompartmental synovectomy, removal of chondral flap, and chondroplasty on 8/31/12. A MRI of the right knee performed on 3/27/13 revealed proximal patellar tendinosis, intrasubstance degeneration within the medial meniscus posterior horn and lateral meniscus, progressive chondral thinning, partial thickness chondral loss and irregularity in the central trochlea, and a small knee joint effusion. Currently, the injured worker complains of right knee pain. Physical examination findings on 2/16/15 included a positive McMurray's sign on the right medial knee with tenderness to palpation of the medial meniscus. The injured worker's pain was rated a 7 of 10, which was worse with weight bearing. The treating physician requested authorization for Butrans 5mcg patch #4 and Voltaren 1% gel 100g #5.

IMR ISSUES, DECISIONS AND RATIONALES

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

Butrans 5 mcg patch #4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Butrans patch. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, Buprenorphine (Butrans).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine section Page(s): 26.

Decision rationale: Butrans patch contains buprenorphine. Buprenorphine is recommended by the MTUS Guidelines for treatment of opiate addiction. Buprenorphine is also recommended as an option for chronic pain, especially after detoxification in patients who have a history of opiate addiction. The medical records do not provide a rationale explaining the decision to utilize this medication in the treatment of this injured worker. Medical necessity has not been established within the recommendations of the MTUS Guidelines. The request for Butrans 5 mcg patch #4 is determined to be NOT medically necessary.

Voltaren 1% Gel 100gms #5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Agents, Topical Anti-inflammatories.

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 medical records do not describe the injured worker as suffering from osteoarthritis. The requesting physician does not provide a rationale explaining the decision to utilize this medication in the treatment of this injured worker. Medical necessity has not been established within the recommendations of the MTUS Guidelines. The request for Voltaren 1% Gel 100gms #5 is determined to be NOT medically necessary.