

Case Number:	CM15-0075614		
Date Assigned:	06/02/2015	Date of Injury:	11/05/2009
Decision Date:	08/20/2015	UR Denial Date:	03/31/2015
Priority:	Standard	Application Received:	04/21/2015

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 53 year old male with an industrial injury dated 11/05/2009. His diagnoses included lumbago, low back pain; hip/pelvic pain, knee pain and joint pain - leg. Prior treatment included right knee brace, diagnostics and medications. He presents on 03/11/2015 with complaints of right knee pain and right hip pain. The provider documents the injured worker is stable with current meds which allows him to be somewhat active and can accomplish most of his activities of daily living except for gardening. He rates his pain as 3/10 with medications. Physical exam of right lower extremity revealed small effusion (knee), tender joint line and positive McMurray's test. Lumbar spine was tender with decreased flexion and decreased extension. Sacroiliac joint was tender. Treatment plan included refill of medications (Avinza, Lyrica, Norco and Voltaren Gel). Most recent urine drug screen was dated 02/10/2015. The provider documented the injured worker did not display any aberrant behavior. The request is for Avinza 45 mg # 30, Lyrica 150 mg # 60, Norco 10/325 mg # 120 and Voltaren Gel 1%, 100 grams 1 refill.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lyrica 150mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy Drug Page(s): s 16-20.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 19-20.

Decision rationale: The MTUS states that Lyrica has FDA approval for painful diabetic neuropathy, post-herpetic neuralgia, and fibromyalgia. The patient is not diagnosed with the above indications. In addition, a recent review has indicated that there is insufficient evidence to recommend for or against antiepileptic drugs for axial low back, knee, or shoulder pain. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly Lyrica 150mg, #60 is not medically necessary.

Norco 10/325mg, #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-94.

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. Opioid use should not exceed two weeks. Despite the long-term use of Norco, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 6 months. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of narcotic. Norco 10/325mg, #120 is not medically necessary.

Voltaren Gel 1%, 100 grams, 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): s 111-112.

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%, 100 grams, 1 refill is not medically necessary.

Avinza 45mg, #30: 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) Pain (Chronic), Avinza (morphine sulfate).

Decision rationale: The Official Disability Guidelines only recommended Avinza for a trial after failure of non-opioid analgesics, short-acting opioid analgesics and after a trial of generic extended-release morphine (equivalent to MS Contin). Avinza capsules are a brand of modified-release morphine sulfate. The patient states his current pain levels as only being a 3 out of 10. The patient is also prescribed Norco for pain. There was no documentation that the patient tried, and failed the above recommendations before prescribing Anviza. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly. Avinza 45mg, #30 is not medically necessary.