MAXIMUS Federal Services

Case Number:	CM14-0123148		
Date Assigned:	08/08/2014	Date of Injury:	06/01/2004
Decision Date:	10/27/2014	UR Denial Date:	07/25/2014
Priority:	Standard	Application Received:	08/05/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 underlying date of injury in this case is 06/01/2004. The date of the initial utilization review under appeal is 07/25/2014. On 07/01/2014, the patient was seen in treating physician follow-up. The patient reported that her bilateral knee strength had improved. She was upset that her medications had been abruptly cut off by the insurer. The patient was diagnosed with chondromalacia patellae as well as lower limb osteoarthritis. The treating physician reported that pain medication had been denied, and there was not much additional treatment to offer. The treating physician refilled medication and recommended that she continue home exercise program and return to the clinic in 2 months.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids/ongoing management Page(s): 78.

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on Opioids/ongoing management, page 78, discusses the 4 A's of

opioid management in detail. The medical records at this time contain very limited documentation of these items, including functional improvement and specific risk factors for aberrant behavior. Overall, these guidelines have not been met to support ongoing chronic opioid use. This request is not medically necessary.

Ambien 10 mg #30: 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) for Pain regarding insomnia treatment

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation/Pain

Decision rationale: Official Disability Guidelines/Treatment in Workers Compensation/Pain states regarding insomnia treatment that Ambien is indicated for short-term treatment of insomnia with difficulty with sleep onset up to 10 days. The medical records in this case do not provide a rationale as to why long-term use of this medication has been recommended. Overall, the records do not provide a rationale for an exception to the guidelines. This request is not medically necessary.

Lidoderm patches 5% #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on Topical Analgesics, states regarding topical Lidocaine that this is indicated only for localized peripheral neuropathic pain after there has been evidence of a trial of first-line therapy. This patient has regionalized pain which may be axial and may be radicular in nature but does not appear to involve a localized peripheral neuropathy for which the treatment guidelines would support the use of Lidoderm patches. This request is not medically necessary.

Voltaren Gel 1%: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on Topical Analgesics, page 112, states regarding Voltaren gel that this is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment, including the knee, which is applicable in this case. A prior physician review recommended non-certification of Voltaren gel with the rationale that the guidelines also state that topical NSAIDs are inconsistent, as noted in the same guidelines, and that the medical records did not indicate a failure of oral anti-inflammatory medications. The treatment guidelines do not specifically require a failure of oral anti-inflammatory medications before considering Voltaren gel; indeed, for a chronic condition, such as osteoarthritis, it is arguable that the guidelines suggest less risk of toxicity from topical anti-inflammatory medications. Although the treatment guidelines state that topical anti-inflammatory medications in general have inconsistent treatment results, the guidelines do specifically discuss an FDA approval of Voltaren gel for osteoarthritis in the knee. Indeed, it could be argued that the guidelines support Voltaren gel, rather than oral anti-inflammatory medications, because oral anti-inflammatory medications do not have such a specific indication for osteoarthritis of the knee. For this reason this request is supported by the treatment guidelines. This request is medically necessary.