

Case Number:	CM14-0146645		
Date Assigned:	09/12/2014	Date of Injury:	11/14/1998
Decision Date:	12/17/2014	UR Denial Date:	08/20/2014
Priority:	Standard	Application Received:	09/08/2014

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 Internal Medicine and is licensed to practice in New York. 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 review indicates the enrollee is a 59 year old male who sustained an industrial injury on 11/14/1998. The mechanism of injury was not provided for review. His diagnoses include right shoulder pain and bilateral knee pain. He continues to complain of right shoulder pain and bilateral knee pain which was worse on the left. On examination of the right shoulder there was no gross deformity, and there was mild swelling. There was increased pain with motion and there was tenderness over the acromioclavicular joint. The Neer's sign and Hawkin's test were positive. The range of motion revealed flexion at 145 degrees, abduction at 120 degrees, and internal and external rotation at 70 degrees. On examination of the knees there was mild effusion in the right and moderate effusion on the left. There was point tenderness upon palpation along the medial and lateral joint line bilaterally. The range of motion revealed flexion at 130 degrees on the right and at 110 degrees on the left, and the extension at 0 degrees bilaterally. Treatment has included medical therapy with Norco, Soma, and Voltaren gel, and physical therapy. The treating provider has requested Norco 10/325mg # 60, Soma 350mg, and Voltaren Gel 100mg # 3.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OpioidsHydrocodone/Acetaminophen Page(s): 76-80, 91, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91-97.

Decision rationale: The documentation indicates the enrollee has been treated with opioid therapy with Norco for pain control. Per California MTUS Guidelines, short-acting opioids such as Norco are seen as an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. Per the medical documentation there has been no documentation of the medication's pain relief effectiveness and no clear documentation that he has responded to ongoing opioid therapy. According to the California MTUS Guidelines there has to be certain criteria followed including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred with this patient. The patient has continued pain despite the use of short acting opioid medications. He should be weaned off of this medication. Medical necessity for Norco 10/325 has not been established. The requested treatment is not medically necessary.

Soma 350mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Antispasmodics Page(s): 65.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41.

Decision rationale: Per the reviewed literature, Carisoprodol (Soma) is not recommended for the long-term treatment of musculoskeletal pain. The medication has its greatest effect within 2 weeks. It is suggested that the main effect of the medication is due to generalized sedation and treatment of anxiety. Soma is classified as a Schedule IV drug in several states. It can cause physical and psychological dependence as well as withdrawal symptoms with abrupt discontinuation. The claimant has a history of opiate dependence. The documentation does not indicate there are palpable muscle spasms and there is no documentation of functional improvement from any previous use of this medication. Per CA MTUS Guidelines muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory medications alone. Based on the currently available information, the medical necessity for chronic use of this muscle relaxant medication has not been established. The requested treatment is not medically necessary.

Voltaren gel 100g #3: Upheld

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

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

Decision rationale: The documentation indicates that the claimant has chronic shoulder pain and bilateral knee pain. He is maintained on medical therapy which includes narcotics and muscle relaxants. Per California MTUS Guidelines, topical non-steroidal anti-inflammatory medications are used for the treatment of osteoarthritis particularly the knee. There is little evidence that supports them as a treatment option for chronic shoulder conditions. The duration of effect is for a period of 4 to 12 weeks with reported diminished effectiveness over time. Medical necessity for the requested item has not been established. The requested treatment is not medically necessary.