

Case Number:	CM14-0098397		
Date Assigned:	09/16/2014	Date of Injury:	12/19/2001
Decision Date:	10/15/2014	UR Denial Date:	05/28/2014
Priority:	Standard	Application Received:	06/26/2014

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 and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 injured worker is a 53-year-old female who reported an injury on 12/19/2001. The mechanism of injury was not submitted for clinical review. The diagnoses included chronic pain, degenerative cervical spondylosis, and myofascial pain syndrome. Within the clinical note dated 04/09/2014, it was reported the injured worker complained of pain rated 8-9/10. Upon physical examination, the provider noted the injured worker had sensitive and painful to touch areas that caused pain which can be felt in other areas of the body. The provider requested OxyContin, Norco, and Voltaren gel. However, a rationale was not submitted for clinical review. The request for authorization was submitted and dated 05/08/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin, 40 mg, QTY: 90, Brand Name: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE, ON-GOING MANAGEMENT Page(s): 78.

Decision rationale: The request for OxyContin 40 mg QTY: 90 brand name is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is a lack of documentation indicating efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the use of a urine drug screen was not submitted for clinical review. Therefore, the request is not medically necessary.

Oxycontin, 10 mg, QTY: 90, Brand Name: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE, ON-GOING MANAGEMENT Page(s): 78.

Decision rationale: The request for OxyContin 10 mg QTY: 90 brand name is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is a lack of documentation indicating efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the use of a urine drug screen was not submitted for clinical review. Therefore, the request is not medically necessary.

Norco, 10/325 mg, QTY 120, Brand Name: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE, ON-GOING MANAGEMENT Page(s): 78.

Decision rationale: The request for Norco 10/325 mg QTY: 120 brand name is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is a lack of documentation indicating efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the use of a urine drug screen was not submitted for clinical review. Therefore, the request is not medically necessary.

Voltaren Gel 1%, QTY: 300 grams: 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 NSAIDS Page(s): 111-112.

Decision rationale: The request for Voltaren gel 1% QTY: 300 grams is not medically necessary. The California MTUS Guidelines note topical NSAIDs are recommended for osteoarthritis and tendinitis, in particular that of the knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.