MAXIMUS Federal Services

Case Number:	CM14-0138341		
Date Assigned:	09/05/2014	Date of Injury:	10/24/2001
Decision Date:	06/19/2015	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	08/26/2014

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. 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: Physical Medicine & Rehabilitation, Pain Management

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 54 year old female who sustained an industrial injury on 10/24/2001. She has a history of cervical spine and right shoulder discomfort and lumbar back pain. Mechanism of injury was not documented. Diagnoses include right shoulder pain, status post-surgery with compensable consequence of left shoulder aching, lumbar strain with left lumbar radiculitis, cervical strain and gastroesophageal upset due to use of pain medication. Treatment to date has included diagnostic studies, medications, surgery, ice, and home exercises. A physician progress note dated 06/30/2014 documents the injured worker complains of shoulder pain right greater than left, low back pain with radiation to the left lower extremity, neck pain, more on the right side, and stomach upset due to pain medications, intermittent. She rates his pain as 3 out of 10. The lumbar spine has mild paralumbar muscle spasm more on the left than the right. Range of motion is restricted. Straight Leg Raise is positive to the left at 80 degrees causing low back and posterior thigh pain. The cervical spine paracervical muscles showed slight spasm more on the right than the left. Range of motion is decreased. Documentation present reveals the injured worker has been on Norco since at least October of 2013. The treatment plan includes medication refills, the continued use of ice and home exercise program as tolerated, to obtain labs and urine toxicology, and follow up in one month. Treatment requested is for Norco 5/325 mg, #60, and Voltaren gel 1%, 100 grams, quantity of one.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5/325 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 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 44, 47, 75-79, 120 of 127.

Decision rationale: Regarding the request for Norco (hydrocodone/acetaminophen), California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function (in terms of specific examples of functional improvement) and no discussion regarding appropriate medication use/aberrant behaviors. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Norco (hydrocodone/ acetaminophen) is not medically necessary.

Voltaren gel 1%, 100 grams, quantity of one: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 111-113 of 127.

Decision rationale: Regarding the request for Voltaren gel, CA MTUS states that topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Within the documentation available for review, none of the abovementioned criteria has been documented. Given all of the above, the requested Voltaren gel is not medically necessary.