

Case Number:	CM14-0194103		
Date Assigned:	12/01/2014	Date of Injury:	04/15/2009
Decision Date:	01/14/2015	UR Denial Date:	11/11/2014
Priority:	Standard	Application Received:	11/19/2014

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 Neuromuscular Medicine and is licensed to practice in Maryland. 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:

This is a 61 year old female who sustained a work related injury on 4/15/2009. She was injured when a bed fell on her foot. Per the Primary Treating Physician's Progress Report dated 9/03/2014 the injured worker reported worsening left ankle pain and knee pain caused by accommodation. She is status-post ankle arthroscopy and fixation. She wears an ankle brace. Physical Examination revealed a healed incision, tenderness to palpation of the anterior joint and pain with terminal PF and resisted motion with some crepitation. This is described as no real change. Diagnoses included osteoarthritis of the ankle and foot and ankle sprain/strain. Prior treatment has included bracing, injections, physical therapy and extensive conservative care. She is noted to be ambulating less and having increased pain. The plan of care included a left ankle arthrodesis. On 11/11/2014, Utilization Review non-certified a prescription for Meloxicam 15mg #30, 2 Refills, and Voltaren Gel 100gm Tube #3 based on lack of medical necessity. The CAMTUS Chronic Pain Medical Treatment Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Meloxicam 15mg #30, 2 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-73.

Decision rationale: Meloxicam 15mg #30, 2 Refills is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines states that this medication is used in osteoarthritis with the maximum dose is 15 mg/day. Use for mild to moderate pain is off-label. The guidelines state that NSAIDS are recommended as an option at the lowest dose for short-term symptomatic relief of chronic low back pain, osteoarthritis pain, and for acute exacerbations of chronic pain. The documentation indicates that the patient has been on Meloxicam for an extended period without evidence of functional improvement and with persistent pain. Additionally NSAIDS have associated risk of adverse cardiovascular events, new onset or worsening of pre-existing hypertension, ulcers and bleeding in the stomach and intestines at any time during treatment, elevations of one or more liver enzymes may occur in up to 15% of patients taking NSAIDs and may compromise renal function. The request for continued Meloxicam is not medically necessary.

Voltaren Gel 100gm Tube #3: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Voltaren Gel 100gm Tube #3 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that Voltaren topical can be used in osteoarthritis in particular, that of the knee and elbow or other joints that are amenable to topical treatment. This is 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. This medication is not recommended for neuropathic pain as there is no evidence to support use. The request as written does not indicate a location for application of the Voltaren Gel. The documentation does not indicate intolerance to medications. The documentation is not clear on the efficacy of prior Voltaren Gel use and how long the patient has used Voltaren Gel. The request as written does not indicate a strength. The request for Voltaren Gel 100gm tube #3 is not medically necessary.