

Case Number:	CM15-0126226		
Date Assigned:	07/10/2015	Date of Injury:	04/11/2002
Decision Date:	09/10/2015	UR Denial Date:	06/26/2015
Priority:	Standard	Application Received:	06/30/2015

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: New York
 Certification(s)/Specialty: Anesthesiology

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 39 year old male, who sustained an industrial injury on 04-11-2002. The injured worker is currently permanent and stationary with permanent disability. The injured worker is currently diagnosed as having long term use of medications, lumbar post-laminectomy syndrome, sacrum disorders, and sciatica. Treatment and diagnostics to date has included lumbar spine surgeries, facet diagnostic injection, lumbar spine MRI which showed L5-S1 neural foraminal narrowing and central canal stenosis at L3-L4, physical therapy with benefit, psychotherapy, and medications. In a progress note dated 05-22-2015, the injured worker presented with complaints of continued low back pain rated 5 out of 10 on the pain scale with intermittent radiation into his left lower extremity. The injured worker denied any change in his pain. Objective findings were unremarkable. The treating physician reported requesting authorization for Voltaren Gel and Hydrocodone-Acetaminophen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren gel 1% one tube: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel (Diclofenac).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 110-111.

Decision rationale: According to the CA MTUS, Voltaren gel 1% (diclofenac) has an FDA appropriation indicated for the relief of osteoarthritis pain in joints that lend themselves to topical treatment, such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. According to the progress notes, the injured worker has complaints of pain in the lower back. The request is not in accordance with MTUS guidelines. In addition, the request as submitted did not specify a dosage for the medication. Given the above, the injured worker is not within recommended guideline criteria. As such, the request is not medically necessary.

Hydrocodone APAP 10/325mg #20: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-going management of Opioids Page(s): 81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-82.

Decision rationale: According to the CA MTUS and ODG, Vicodin 10/325mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." In this case, the treating physician does not document the least reported pain over the period since last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, how long pain relief lasts, or improvement in function. These are necessary to meet the MTUS guidelines. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested treatment with Hydrocodone/Acetaminophen 10/325 mg is not medically necessary.